



**U. S.
NAVY**

Medicine



August 1975

UNITED STATES NAVY MEDICINE

Vol. 66

August 1975

No. 2

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The issuance of this publication approved in accordance with NAVEXOS P-35.

NAVMED P-5088

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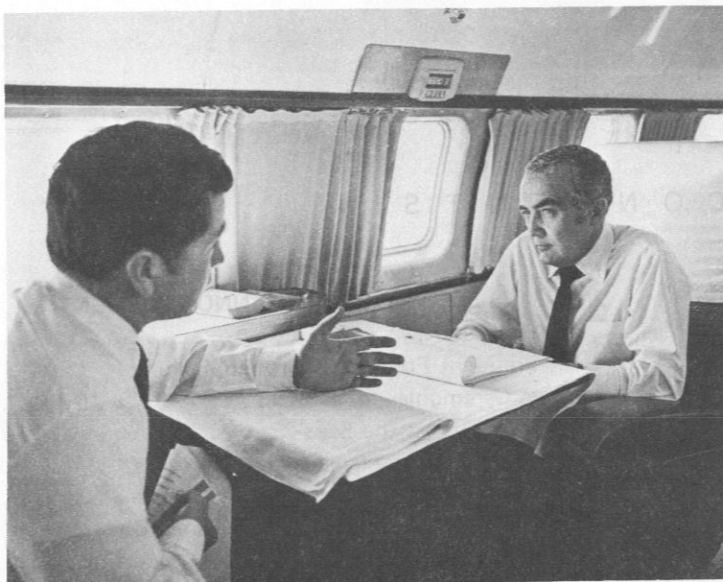
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COVER: Last March, fire destroyed the second floor and one of two wings of the Branch Dispensary at Indian Head, Maryland. Branch dental facility equipment and supplies were lost in the blaze. On page 6 CAPT G.D. Pirie (DC) reports on the fire and on the dental mobile maintenance facility that was temporarily used to provide dental services after the fire.

The continued support of the Media Division, Educational Programs Development Dept., Health Sciences Education & Training Command (HSETC), NNMC, Bethesda, Md., is gratefully acknowledged.



from the Chief

In late 1964 President Johnson formally declared war on waste in the Federal Government by launching a systematic and long-range Government-wide cost reduction program. Circular A-44 of the Office of Management and Budget directed all elements of the executive branch of the Federal Government to establish and formalize a Management Improvement Program. This Federal statute, revised on 16 February 1970, emphasized the President's major concern for improving the efficiency and economy of Government operations. It further stated that each individual in Government should be motivated to be constantly alert to the development and application of better ways to perform day-to-day tasks.

The Chief of Naval Operations then issued a directive establishing the Department of the Navy Management Improvement Program, with the Chief of Naval Material designated Navy program manager for its operation and management. NAVMATINST 5300.30 required organizations (including BUMED) to issue appropriate instructions and monitor continuing progress to assure that all headquarters elements and subordinate activities actively supported and participated in the program.

The Management Improvement Program consists of five interrelated elements:

- Management effectiveness
- Cost reduction
- Idea interchange
- Presidential recognition of exceptional improvement actions
- Periodic study of Government-wide operations

To us in the Navy Medical Department these cost reduction efforts meant not only that our services and programs had to be maintained at the lowest possible cost to the taxpayers, but also that they should remain the best possible services for beneficiaries seeking the high-quality health care to which they are entitled.

In FY 74 and FY 75 our goals were to achieve savings of \$405,000. In FY 74 we realized savings of \$342,100, approximately 84% of our assigned goal. I am now proud to report that, while retaining our high standards of service and at the same time putting into effect cost reduction methods, we have achieved savings of \$996,660, representing 246% of our assigned goal for FY 75.

Here is a summary of the cost reduction actions that produced these savings:

<u>Actions</u>	<u>Savings</u>
Utilizing excess materiel	\$388,370
Combining/eliminating job functions	192,000
Streamlining training programs	107,000
Revising operating procedures	73,705
Contracting out vice doing in-house	63,600
Eliminating nonessential tasks	61,000
Doing work in-house vice contracting out	44,065
Item substitution	28,090
Revising civilian personnel grade structure	15,725
Energy conservation	15,000
Material reutilization	4,190
Procuring labor saving equipment	2,590
Procurement vice leasing or contracting out	1,325
Total FY 75 savings	\$996,660

These figures represent the efforts of Medical Department personnel who have searched for better ways to do their job. The figures also represent the managers who motivated personnel to find ways to effect savings, to help identify the savings that had been accomplished, and to insure that the savings were reported. Finally, they represent the personnel who assisted in identifying savings, determined that the information reported was a creditable cost reduction, and ascertained that the amounts reported were accurate. All of these personnel have performed most competently, but their accomplishments in the FY 75 Cost Reduction Program were especially gratifying and significant.

A combination of many contributing factors affected personnel concerned with all areas of cost reduction: individuals responsible for management improvement ideas, the administrators, and the financial managers. But the principal, often intangible factor has been the integration of old and new management attitudes and techniques, resulting in the adoption and dissemination of more cost reduction ideas.

We are constantly seeking ways to do our job at less cost while continuing to improve the quality of our services. Improving quality and reducing costs are objectives for managers at all our field activities, and each manager must understand that meeting these objectives lies in his sphere of responsibility.

Only when the entire work force becomes acutely cost conscious can our mission be accomplished. This basic philosophy must be implanted at the top of the organization and allowed to filter downward. Top management must set the objectives, direct the effort, and insist on accomplishment.



The Navy Dental Corps:

Quality Dental Care in Peacetime

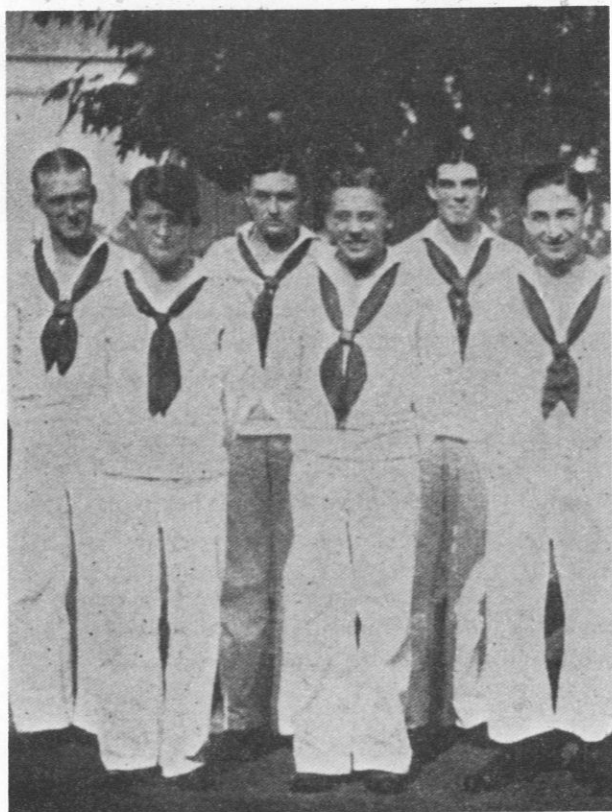
The goal of the Navy Dental Corps throughout its 63 years of existence has been to deliver quality dental care to Navy and Marine Corps personnel ashore and afloat. With modernization of its resources, the Corps continues to support the active forces during times of war and peace.

Some 1,750 dental officers now serve worldwide in 200 dental installations, including 78 dental facilities in ships, 8 dental companies with the Marine Corps, and 9 mobile construction battalions. There is a reserve organization of more than

3,000 experienced officers, about 2,000 of whom serve in the Restructured Naval Reserve Program.

With the establishment of 7 new regional dental centers in April 1975 the Navy now has 19 such regional centers, providing for more efficient use of both personnel and materiel resources. Regionalization has caused a significant increase in dental treatment for our active forces.

The Dental Research Program continues to sponsor dynamic projects aimed at developing a more cost effective oral health care delivery system. The Naval Dental Research Institute, the major Navy laboratory committed to dental research, is now in new improved facilities in Great Lakes, Illinois.



Pictured above is part of the second class of dental technicians, who graduated from the Naval Dental School in 1923, wearing what has become a historic uniform for enlisted naval personnel.



June 1942: LT W.B. Jones (DC) cares for a patient aboard the USS *Long Island* (CVE-1) during World War II.



In the 1950's oral hygiene instruction was offered at the Naval Dental Technician School, Bainbridge, Maryland.

Ensuring a professionally stimulating and rewarding career in the Navy Dental Corps remains one of the Dental Division's top priorities. To help achieve this goal, the National Naval Dental Center (formerly the Naval Graduate Dental School) offers a two-year program in comprehensive dentistry that permits dental officers to participate in all dental disciplines.

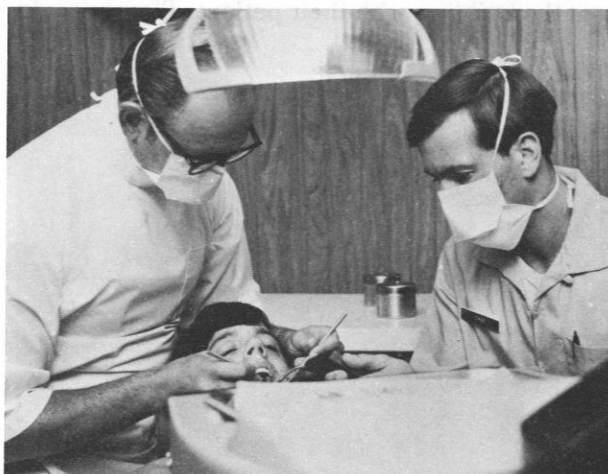
Dental military construction is presently at its greatest level, with many facilities under construction. These facilities will provide for both comprehensive and specialty treatment of patients, and will introduce the use of radial operatories for oral health care.

An exhibit of historical dental memorabilia is being considered for the Naval Museum in Washington, D.C., during the period of our country's Bicentennial celebration. Historical artifacts are being sought for such a display.

The Navy Dental Corps is proud of its heritage and its accomplishments. With the use of modern dental technology and management, it stands ready to maintain the oral health of the operating forces of the Navy and Marine Corps. 🍷



August 1962: LT H.P. LeBlanc, DC, USNR, serving with the Fleet Marine Force in Vietnam, provides dental care in the field.



Comprehensive dentistry continues to be provided by today's Dental Corps.

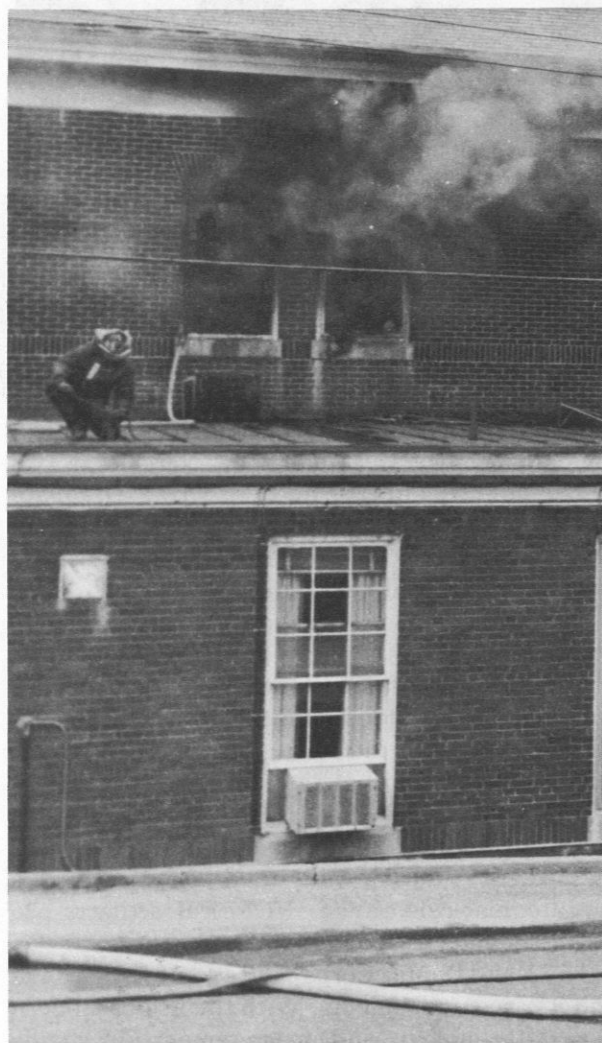
Fire at Indian Head

On 7 March 1975 the fire alarm sounded in the Branch Dispensary at Indian Head, Maryland. Dental officer CAPT George D. Pirie and his assistant, DT2 Joseph R. Harris, were on duty, treating a patient in the branch dental facility located on the second floor of the main building. Also on duty was the administrative petty officer DT1 Karl W. Henry. They all assumed that the alarm was only part of a drill until HN David A. Conn came by the office shouting that the building was really on fire.

After closing the drawers of the metal file cabinets that contained dental records and turning off the electrical switches, the dental staff hurried from the building with their patient. Flames could



The Indian Head Fire Department fights the blaze at the Branch Dispensary, Indian Head, Maryland. The fire gutted the second floor of the main building, and one of two wings.

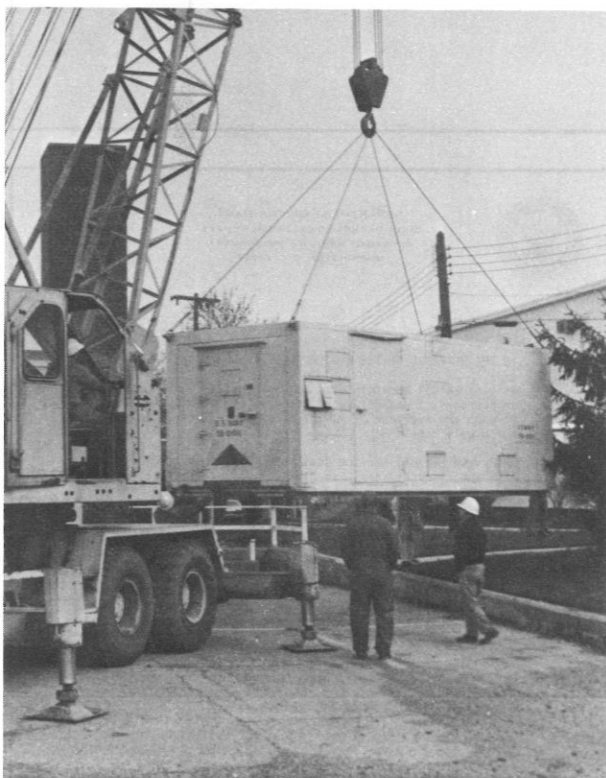


The branch dental facility, located on the second floor of the main building, was destroyed in the fire.

already be seen around the door of a storage closet next to the stairway. Apparently, the fire had been burning for some time before it was discovered. All personnel were safely evacuated from the dispensary in less than ten minutes, as fire companies arrived to fight the blaze.

HMC Albert J. Majni directed the removal of health records and some equipment from the first floor. It was impossible to return to the second floor dental spaces, and all dental equipment and supplies located there burned, melted, or were damaged by smoke and water. However, because the metal filing cabinets were closed before the office was secured, most dental records were saved and were usable, even though many were singed and damaged by smoke.

The building that housed the medical and dental spaces was a brick shell with wooden trim, rafters, and studs. The fire gutted the second floor of the main building and one of two wings. When reviews and estimates showed that rebuilding the dispensary to 1975 standards was not immediately feasible, a decision was made to construct a new facility sometime in the future. A temporary



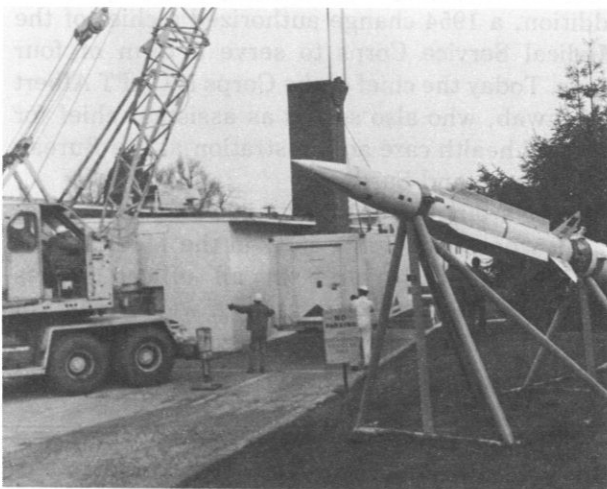
A mobile maintenance facility (dental), transported from Camp Lejeune to Indian Head, is lifted from a flat bed truck with the use of a crane.

dispensary was quickly set up in an abandoned mess hall. No space could be provided in this building for a dental operatory, and since there were no other appropriate facilities on the base CAPT Pirie asked the Bureau of Medicine and Surgery for temporary dental facilities in order to continue dental treatment as soon as possible.

On 20 March 1975 a mobile maintenance facility (dental) arrived from Camp Lejeune, North Carolina, on a flat bed truck. The van had been developed by the Naval Dental Research Institute, Great Lakes, Illinois, for field use with the U.S. Marine Corps, Seabee, and fleet units, and had been undergoing field trials at Marine Corps Air Station, Cherry Point, North Carolina. It was transported to Indian Head for its first use in an actual emergency situation.

With the use of a crane, base public works personnel positioned the van, supported on its own jacks, on a hard surface close to required utilities. DT1 Samuel W. Shelton, a research technician, came to Indian Head from Camp Lejeune to help set up the van.

In about two days the van was ready for use. The two-chair, fully equipped facility enabled the dental staff to render comprehensive dentistry, with the exception of routine prosthetic care. This immediate capability allowed the branch medical and dental facility at Indian Head to continue its mission with a minimum of cost and patient delay.—CAPT G.D. Pirie, DC, USN, Branch Dental Facility, Indian Head, Maryland. 🇺🇸



The dental mobile maintenance facility is placed in position at Indian Head. The fully equipped two-chair facility enabled the staff to render comprehensive dental care, with the exception of routine prosthetic care.

Medical Service Corps Celebrates 28 Years

Members of the Navy Medical Service Corps will celebrate the 28th anniversary of their Corps on 4 August 1975.

The Medical Service Corps was founded by the Army-Navy Medical Service Corps Act of 1947. This legislation was the result of bills introduced to the House and Senate by both the Army and the Navy some six months apart. The Navy actually introduced two different bills: one to "establish the commissioned grade of Medical Administrator in the Hospital Corps of the Navy and for other purposes"; the other to "establish the Medical Associate Sciences Corps in the Medical Corps of the Navy." Congress combined these two bills, along with the single bill introduced by the Army, into the single Act of 1947, which became Public Law 337 of the 80th Congress.

The 1947 Act that established the Navy Medical Service Corps has been changed somewhat in the intervening years. Originally the Corps had three sections—Pharmacy, Supply and Administration; Optometry; and Medical Allied Sciences. Since then a separate Pharmacy Section has been established, and two new sections—the Medical Specialist Section and the Podiatry Section—have been authorized by the Secretary of the Navy. In addition, a 1954 change authorized a chief of the Medical Service Corps to serve a term of four years. Today the chief of the Corps is CAPT Albert J. Schwab, who also serves as assistant chief for regional health care administration at the Bureau of Medicine and Surgery.

There are now more than 1,700 officers, including 93 women, on active duty in the Medical Service Corps. They serve in all officer grades through captain, and represent a wide variety of academic disciplines, ranging from research and the allied sciences to hospital administration and management.

Medical Service Corps officers serve ashore and afloat, on the staffs of major fleet commanders and with the Marines, and with the district commandants. The Corps currently has 50 medical department facilities under its direction or command, including two naval hospitals. 🍀



THE SURGEON GENERAL OF THE NAVY

TO THE OFFICERS OF THE MEDICAL SERVICE CORPS

May I take this opportunity to offer each of you my warmest personal greetings on this, the twenty-eighth anniversary of the founding of your Corps.

The Medical Service Corps has always provided the expertise necessary to enhance the delivery of patient care and the fulfillment of our mission to the Naval Service. Now, with the advent of new requirements and challenges, you must not let down. You cannot afford the luxury of dwelling on past accomplishments. You must forge ahead, meeting each new challenge head on, if you are to continue as a viable, integral part of the Medical Department team. I am confident that you will continue to perform your duties in a most exemplary manner and will seize each new opportunity with vigor. Together, we shall overcome any obstacle placed in our path.

Best wishes for a Happy Birthday.

D. L. Custis
D. L. CUSTIS
Vice Admiral, MC, USN



DEPARTMENT OF THE NAVY
CHIEF OF THE MEDICAL SERVICE CORPS
BUREAU OF MEDICINE AND SURGERY
WASHINGTON, D. C. 20372



TO THE OFFICERS OF THE MEDICAL SERVICE CORPS

As the Medical Service Corps celebrates its twenty-eighth anniversary, I would like to take the opportunity to extend to each and everyone of you my personal congratulations for a job well done.

While the Medical Service Corps has grown in size over the past twenty-eight years, so have its responsibilities. In every case you responded to the challenge with vigor and enthusiasm. The mature judgement you demonstrated in meeting these new obligations has been noted and most surely indicates your capacity to assume even greater responsibility in the future.

You can be sure that the forthcoming year will offer many challenges, some new and some old, but all interesting. Often they may appear to be overwhelming; but I am confident that you will continue to direct your attention to assuring the provision of the best medical care possible. I would recommend you consider the challenges opportunities to demonstrate your capability and potential in ensuring that the Navy's health care delivery system will be second to none. In this task each of you has a vital role to perform and I am certain you will do your utmost to assure our success.

As you join with the other Corps of our Medical Department team in focusing your attention on enhancing the delivery of health care, I offer to you my best wishes and extend my gratitude for your dedication and support.

A. V. Schwab
A. V. SCHWAB
Captain, MSC, USN

HEALTH CARE EVALUATION: IT REALLY WORKS!

LCDR Robert K. Zentmyer, MSC, USN

The need for quality control over the provision of health care services has been widely discussed, with most health care professionals now acutely aware of potential threats to patients created by deficiencies or excesses in the areas of testing, treatment, hospitalization, and surgery (1). This awareness is strengthened by:

- a dramatic rise in patients' expectations regarding health care;
- court decisions explicitly placing ultimate responsibility for the quality of care on the governing bodies of health care institutions;
- increased Government regulation of the health care industry;
- rising costs of health care;
- institution by organizations such as the Joint Commission on the Accreditation of Hospitals (JCAH) of tougher standards of quality control (2).

Stated simply, the American public expects members of the medical profession to provide high-quality health care at the lowest possible cost, and to eliminate all unnecessary care.

These developments affect Federal institutions as well as civilian organizations. Military medicine has always been committed to providing the highest quality health care to its beneficiaries. In the face of additional pressures brought about by decreasing resources and increasing workloads, it is readily apparent that Federal medicine in general, and Navy medicine in particular, must become even more concerned with the cost effectiveness of its health care delivery system. Some method for objectively measuring the quality and amount of health care being provided is essential if appropriate decisions are to be made regarding policies, procedures, and methods of health care delivery.

LCDR Zentmyer is deputy director of administrative services, Naval Regional Medical Center, Long Beach, California 90801.

PRINCIPLES OF QUALITY CONTROL

When one begins to examine quality control in the health care field, a torrent of terms spews forth: peer review, medical audit, quality assurance, patient care evaluation, utilization review, PSRO. No wonder there is confusion.

What exactly is involved in a quality control program? How do all the pieces fit together? Probably the clearest explanation of the types of review which make up a total program is set forth in the American Hospital Association publication *Quality Assurance Program* (3). This manual divides quality control into three types of measures: prospective, concurrent, and retrospective. *Prospective measures* are those methods which look ahead and attempt to prevent substandard health care. Such measures include pre-admission review and certification, and pre-admission testing. The objective is to prevent unnecessary medical care, especially expensive inpatient care. *Concurrent measures* study the process of medical care while it is actually taking place. These measures may include review of length of stay, utilization of diagnostic facilities, and preparatory planning for care of patients after discharge from the hospital. *Retrospective reviews* look backward at the care provided to determine any deficiencies or excesses. Action may then be taken to prevent recurrence of flaws or errors which detract from high quality medical care.

Regardless of the name it goes by, then, quality control consists of *control over inputs, process, and outcomes on a prospective, concurrent, and retrospective basis*.

Most authorities tend to concentrate on process or outcome and to avoid, for political or other reasons, advocating quality control over inputs; however, they generally agree that the usual procedures followed in medicine must be reversed

when establishing a quality control program: the desired outcome must be determined *before* the process which leads to that outcome can be examined.

If quality control in the health care delivery system involves prospective, concurrent, and retrospective measures, then medical audit (patient care evaluation) is obviously only one portion of the system—the retrospective portion. But it is the key to the total system, since it provides the system's standards or criteria. JCAH has chosen to concentrate on this aspect of quality control.

A CHANGE IN APPROACH

Since its establishment, the JCAH has been concerned with quality assurance mechanisms. This concern has found expression in four requirements for accreditation:

- effective medical staff credentials functions;
- adjunctive protective devices through such mechanisms as infection control and pharmacy and therapeutics policy functions;
- patient care evaluation through both retrospective (patient care audit) and concurrent (utilization review) programs;
- programs of continued medical education, as determined by demonstrated current educational needs of the hospital staff.

While the JCAH has been more or less satisfied with the performance of the first two functions, it has found that the traditional methods of patient care evaluation have not been effective. First, the methods generally used are not systematic; usually performed on a random basis, such evaluations frequently do not reflect the bulk of care given, and rarely lead to corrective action. Second, the traditional chart review approach required that physicians do most of the analysis. Third, the review considers whether care is adequate in individual cases, but does not reflect patterns of care. Fourth, since it relies on the judgment of an individual physician, the review is necessarily subjective, and the standards of the review vary depending upon the reviewer involved. Fifth, the traditional review generally is not adequately documented and rarely produces reliable information on which to make constructive change. Finally, and probably most important, in chart review the burden of evaluation is placed entirely on the reviewer, rather than on the

system; in other words, chart review requires one physician to evaluate (and perhaps criticize) another physician.

To overcome these problems, the JCAH now advocates a more systematic approach to medical audit, with the goals of:

- reducing the amount of time physicians spend in peer review, while maintaining professional control;
- emphasizing patterns of care rather than individual cases;
- insuring that acceptable cases are screened out, thereby reducing the professional review workload;
- providing an overall picture of care provided;
- substituting objective or explicit criteria for subjective evaluation;
- placing the burden on the system rather than on the individual physician reviewer;
- insuring corrective action is taken when required.

While the JCAH does not insist upon any one system of audit, even its own, it does list six essential requirements of any system:

(1) It must be objective. Predetermined criteria must be developed which represent optimal care for the patient, are achievable by the institution, and are acceptable to the medical staff in general.

(2) It must be efficient, specifically in terms of physician time. The number of charts a physician reviews must be reduced to those which demonstrate a variance from adopted criteria. The sorting process to detect such charts need not be done by physicians.

(3) It must be fully documented. Actual practice must be compared with adopted criteria; all variances must be explained, and corrective action indicated.

(4) It must be clinically sound. Elements of adequate care must be adapted to local standards, with allowable exceptions designated.

(5) It must be flexible. The clinician need not conform blindly to all established criteria but must explain any variance to his peers (hence "peer" review).

(6) It must be action oriented. Identified deficiencies must result in documented corrective action. This implies that deficiencies must be identified as arising either from a lack of knowledge or from failure to use knowledge appropriately, and that the deficiency must be attributable to a specific individual or thing (e.g., the institution, management, policies, the entire

staff, or a single practitioner). Only then can the appropriate corrective action be taken.

THE JCAH SYSTEM

The audit model accepted by the JCAH focuses on the entire health care team and encourages all disciplines to work together to improve the quality of patient care. The entire process is accomplished on carefully designed worksheets that themselves fulfill reporting requirements. The system is based on the principle that an effective audit procedure must evaluate the *outcome* of care before it evaluates processes by which the care was rendered. Most authorities believe in the superiority of outcome-oriented care because such care evaluates whether patients actually do as well as predicted, and attempts to discover reasons when they do not (4). Flexibility is provided by considering alternative courses to the outcome, thus allowing for differing circumstances, clinical judgments, and social and economic characteristics of the patients. The JCAH system also provides a process evaluation component for use when outcome audit discloses such a need. In addition, this system has the additional

advantages of full documentation inherent in the proposed worksheets, and the capability for manual or machine processing of information.

The JCAH system departs from the traditional methods of audit in three primary areas. First, because charts are screened by ancillary health care personnel, physicians need review only unacceptable cases, thus significantly reducing the time physicians spend in the audit process. Second, the complete system is based upon predetermined criteria developed by physicians, thus providing for objective review and professional control. Third, the system replaces horizontal audit with vertical audit, thereby reducing the proliferation of quality control boards and committees.

THE JCAH SYSTEM IN ACTION

Table 1 shows the JCAH system in action at Naval Regional Medical Center Long Beach, California. JCAH recommendations for the development and implementation of the Medical Audit Program are compared with action already taken at NRMC Long Beach, or proposed for future implementation.

TABLE 1. Development and Implementation of Medical Audit Program
at NRMC Long Beach, California*

IMPLEMENTATION

NRMC Action

1. Implement the Medical Audit Program concurrently with utilization review programs. Criteria developed for the Medical Audit Program will replace utilization criteria for specific diagnoses or conditions.

2. Each clinical department establishes one or more audit committees. These committees select the topics to be audited, and the order in which topics will be reviewed.

1. Significant steps have been taken to implement the Medical Audit Program. As early as 21 May 1974, a memorandum was disseminated to all chiefs of services directing the preparation of audit criteria for predetermined admission diagnoses.

2. Instead of departmental audit committees, a central committee will be established, initially composed of representatives from major services. The committee shall independently determine topics to be audited. Topic selection is made by the clinical department, with each department functioning as a departmental audit committee for protocol preparation and implementation.

3. The basic essential criteria established by the Audit Committee for the topic to be studied should reflect appropriate care and achievable patient outcomes. If the established criteria cannot be answered "Yes, it was met" or "No, it was not met," clarification is needed.

3. As noted above, preparation of audit criteria (protocol) has been initiated. Instead of the central audit committee establishing these criteria, each service shall establish criteria for specific categories and shall submit these criteria to the central audit committee for review and approval. Twenty-five protocols were completed by the end of September 1974; it is anticipated that an additional 25 protocols shall be developed each year thereafter. The Command's initial audit was conducted 2 July 1974, using a protocol developed for chronic tonsillitis. Results of the audit were generally satisfactory for protocol content, data display, and review participation. The trial audit was conducted by the Medical Records and Utilization Review Committee. Since then some ten audits have been completed; two more were in process as of 15 April 1975.

DATA COLLECTION

1. The Audit Committee assistant reviews charts for the topic selected by the Committee. (The assistant may be a nurse, medical record administrator, or medical record clerk.) Data collected by this review reflects conformance to and variance from established protocol standards, and is composed of three "screening" steps:

Justification: Validates purported diagnosis, clinical indicators for admission, and operative or other special procedures performed.

Patient outcome: Status at discharge is within expected range; no unacceptable complications develop either during or after hospitalization; length of stay is within recognized norms.

Exceptions: Exceptions modify established standards; variance from the protocol is justified.

Any record that fails to satisfy one or more of the screening steps shall be presented to the Audit Committee for further review.

2. The chairman or a member of the Audit Committee should act as liaison between the Committee and the assistant. The liaison physician will determine whether any of the criteria are inappropriate, will answer questions that did not arise during the criteria-setting session, and may further define terms and protocol criteria. All charts that fail to meet diagnostic justification must be referred to the liaison physician, who will decide whether the chart is to be referred to the Committee for disposition.

1. Review of records for chronic tonsillitis was accomplished over a two-week period by a medical record technician. Because the review was conducted in addition to regularly assigned tasks, an inordinate amount of time was expended. During September one full-time employee was hired; another will be on board by 1 May 1975. The review observes the three screening steps. Charts with discrepancies are presented to the Committee for audit. If variances from the established protocol are not justified, steps will be taken to prevent future occurrence.

2. Instead of appointing one physician to serve permanently as liaison between the Committee and the assistant, the Committee member whose service is responsible for the topic under audit acts as liaison physician, and is a source of professional knowledge about the topic. In addition, the chief of service or his delegated representative serves as liaison for departments not represented on the Audit Committee.

MEDICAL AUDIT PROCEDURES

1. The Committee reviews each variation to determine its classification as a "deficiency" or an "exception." The Committee shall determine the probable reason and type of each variation classified as a "deficiency":

Reason: Institutional barriers such as equipment deficiencies, inappropriate administrative policies, or noncompliance with established protocol standards.

Type: Lack of necessary knowledge or skill; failure to accomplish a known appropriate step or procedure.

When a deficiency is identified, the Committee must decide upon corrective recommendations, and determine to whom to direct those recommendations. A member of the Committee may be assigned to monitor corrective action.

1. Charts at variance from established criteria are presented for audit. Any deficiencies noted are brought to the attention of members of the Committee for determination of corrective action. It is anticipated that with the establishment of a permanent Medical Audit Committee composed of representatives from the major services, all corrective recommendations may be relayed to the appropriate member at the time a deficiency is recognized. A general discussion shall be conducted to determine the most appropriate corrective action; the recommendation shall then be presented to the appropriate Committee member for implementation. It is felt that concurrent monitoring of remedial action is not generally necessary. A summation report by the cognizant Committee member, describing the corrective action taken and the results, will suffice.

MEDICAL AUDIT REPORTS

1. The Committee reports the entire audit through service, department, staff, management and governing body channels to insure that remedial action has been initiated and implemented at the appropriate level.

2. The Committee shall reassess the results of the audit at a specific time.

3. The documented audit is maintained at the hospital for future reference, and for review by the JCAH survey team upon request.

1. Minutes of the Audit Committee meeting shall be recorded and disseminated to appropriate areas within the region. Remedial action shall be initiated by the permanent Committee member on whose service the deficiency has been identified. Implementation of corrective action is a departmental matter, and shall be left to the discretion of the chiefs of the various services.

2. Depending upon the severity of deficiencies, the Committee may reevaluate a topic on a rotational basis, or may accelerate the review to coincide with planned completion of corrective action.

3. The audit report and minutes of the Audit Committee shall be retained within the Command for at least five years, at which time they shall be forwarded to the Federal Records Center, St. Louis, Missouri, for permanent retention.

*This summary was developed by LTJG C.S. Day (MSC), Assistant Chief, Patient Affairs Division, NRMC Long Beach, California.

Approximately 32 audit criteria sheets have already been submitted by the various clinical services at NRMC Long Beach, including dental, dermatology, otorhinolaryngology, gynecology, ophthalmology, orthopedics, pediatrics, psychiatry, surgery, and urology. Fourteen of these criteria sheets have been presented to the Medical Records and Utilization Review Committee, which acts as an interim Medical Audit Committee. Several deficiencies have been identified, and corrective action taken.

A central patient care evaluation committee (medical audit) is being planned. This committee will initially be composed of the chiefs of the family practice, internal medicine, Ob/Gyn, orthopedics, and surgery services, and the audit committee assistant. The Medical Records and Utilization Review Committee will then be used only as a utilization review body (a subcommittee of the PCE Committee).

On 1 July 1975 the patient care evaluation program will be revised to permit the goal of four audits per month to be achieved by July 1977. The PCE Committee will eventually become an "umbrella" committee, responsible for coordinating the overall evaluation program (Figure 1).

Medical audit will be performed by four departmental audit committees, with one audit accomplished each month in the areas of surgery, medicine, Ob/Gyn-Pediatrics, and other specialties. Nursing audit and utilization review will be performed by subcommittees already established. Ultimately the Pharmacy and Therapeutics Committee will be included in the system as a subcommittee.

The chairman of each subcommittee will be a member of the Patient Care Evaluation Committee (chaired by the director of clinical services). Each subcommittee will report the results of its audits to the PCE Committee for coordination and report to the commanding officer.

We have found that the JCAH-proposed audit system works well in a military setting provided that the following requirements are observed:

First, the full cooperation of all personnel must be secured. At NRMC Long Beach little progress was made until one individual was designated to coordinate implementation of the system. We assigned this duty to a Medical Service Corps officer, who discussed the system with individual chiefs of services, explaining the potential benefits and helping to formulate criteria sheets.

Second, in many cases two sets of length-of-stay criteria were developed, one for active-duty military and one for supernumerary patients, because the patient status on discharge differs in these two categories.

Third, some mechanism must be specifically designed into the system to prevent excessive care, which is difficult to detect when medical audit is based upon outcomes. Whether detecting excessive care is a legitimate function of medical audit or should be the exclusive jurisdiction of utilization review is a question which each command must answer individually.

Finally, we found that although the system demands less physician time, it requires considerably more administrative support than previous methods of audit; even our limited pilot studies required the full-time services of a trained

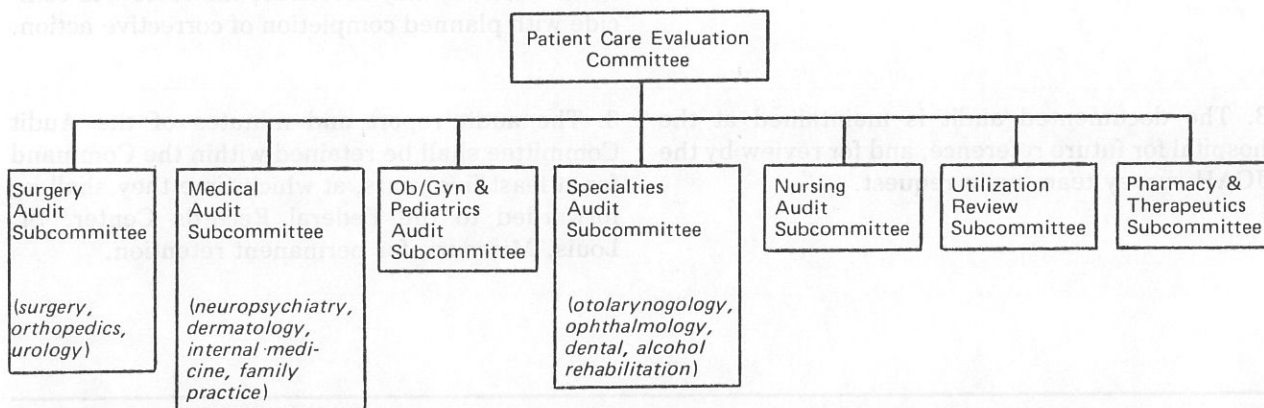


FIGURE 1—Proposed overall evaluation program.

medical record technician. This requirement must be considered when implementing such a medical audit system.

It has also become apparent that the Navy's multiple-hospital system, in which physicians are transferred between facilities, requires some uniformity in medical audit procedures. It would seem advisable that a Navy-wide, and preferably a DOD-wide, system should be developed to increase efficiency and promote information exchange between activities.

SUCCESS OR FAILURE?

Carter Zeleznick identified ten basic principles essential to a successful medical audit procedure. Navy medical facilities undertaking such a task should carefully consider his advice:

1) Be selective about which aspects of patient care are evaluated.

2) Choice of topics for evaluation should reflect the frequency and severity of patient disability if treatment is not rendered, and the effect of appropriate medical intervention in reducing that disability.

3) Only the most important areas should be evaluated.

4) In developing criteria the usual medical inquiry procedure should be reversed; outcomes should be evaluated before the process that led to those outcomes is examined. This is particularly true for retrospective studies.

5) Data to be examined should not be determined by its availability.

6) Patient care evaluation criteria should be flexible rather than absolute.

7) All phases of the medical audit must be given active support.

8) Extreme caution should be used in applying statistical techniques to patient care evaluation data, since the samples are small and may hide important facts.

9) Deficiencies in patient care should generally be corrected through the hospital education program; there should be no punitive implications.

10) Because a limited, topic-oriented approach to patient care evaluation cannot be comprehensive, and because the activity itself may be the most potent means of producing change, the process must be frequently repeated.

THE ART OF MEDICAL AUDIT

The science of medical audit is concerned with procedures and mechanics. But the art of medical audit considers the benefits medical audit provides for patients. It is important, therefore, to understand what medical audit is *not*. Medical audit is designed to evaluate individual, group, and institutional performance in a visible, objective, efficient, and systematic manner. It is *not* research, *not* instruction, *not* management, and *not* a protocol for health care delivery, although the results of audit may affect all these areas. Moreover, audit alone will not satisfy the requirements for effective utilization review or other cost containment techniques, although it will have a desirable influence on cost-related evaluation activities.

Change is a way of life in today's world. How the health care practitioner responds to change will determine his survival and professional growth.

Dr. Peter Rogatz concludes his *Hospitals* article on medical audit with a statement that applies as much to military hospitals as to civilian:

In the last analysis, society has the right to understand what goes on in the health care field and to judge every health care provider, carrier, and intermediary on the basis of performance. Physicians, dentists, hospitals, and nursing homes, and even third-party payers are no more immune to self-interested behavior than are bankers, barbers, bus-drivers, barristers, or any other group. No matter how much we would like to think ourselves as imbued with a unique concern for the public interest that should exempt us from public scrutiny, there is no evidence for granting us such immunity.

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THE WORD PROCESSING UNIT: GOODBYE TO BACKLOGS

By LT Joseph R. Steiner, MSC, USN
ENS Albert S. Gesh, MSC, USN

Since the establishment of a new word processing unit—combining endless loop dictation equipment, centralized transcription services, magnetic tape text-editing power-typing equipment, and the data processing reporting procedures—medical reports at the Naval Regional Medical Center, Oakland, California, are being transcribed within 24 hours of their dictation.

Rapid transcription of medical dictation is a welcome change for the medical center, which had been faced with a huge and growing backlog of dictated medical reports and a lag of four to six weeks between dictation and transcription. Realizing the severity of the problem, the medical center's commanding officer, RADM R.E. Faucett (now retired), directed that a comprehensive study be conducted to identify and eliminate the causes of the delinquent dictation. The management team assigned to conduct the study quickly identified several serious problems:

- Existing transcription was decentralized, with inpatient, radiology, and pathology reports being transcribed in different areas of the medical center.

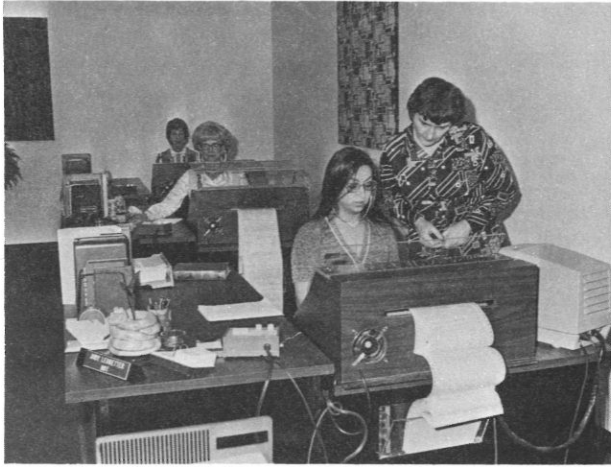
- Transcription areas were crowded and uncomfortable; transcriptionists were constantly plagued with interruptions by staff and patients.
- There were too few transcriptionists; any absence for sick leave or annual leave caused a severe drop in production.
- The daily input of dictated material was greater than the amount of material being transcribed; therefore, the existing backlog of dictation continued to grow.
- The dictation equipment was obsolete, its voice reproduction poor.
- Employee morale was marginal.

To correct these problems and provide a faster "turnaround time" (time required to transcribe dictation and return it to the originator), the management team advised the commanding officer to:

- Centralize the medical center's transcription services, bringing together radiology, pathology, and inpatient transcription into one central unit.
- Relocate the new centralized transcription unit in an area that would provide optimum working conditions for employees, with fewer interruptions.
- Transfer the transcription function to the Data Processing Service, creating a Word Processing Branch.
- Contract the backlog of dictation to a civilian firm until the new word processing system could be introduced.

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Word Processing Manager Mrs. Rosalind B. Raab supervises the work of a medical dictation transcriptionist. Reports are first typed in the rough on single, continuous-form pages.

- Staff the centralized word processing unit to provide 24 to 48 hours' turnaround time of routine dictated material.
- Replace the obsolete and inadequate discrete media dictation system with a dictation system utilizing the endless loop recording media.
- Obtain power-typing (text-editing) equipment for all transcriptionists.
- Hire a professional word processing manager to manage the Word Processing Branch.

A MORE EFFICIENT SERVICE

In January 1974, we were assigned to design and develop a more efficient transcription service. To house the new word processing unit we selected a 1,300 square foot room, formerly used for the medical center archives. This location placed the unit in a low traffic area of the medical center, conveniently across from the Data Processing Service. Wall-to-wall carpeting, vinyl acoustical wall covering, soft lighting, and modern office furniture and accessories were installed.

Following a comprehensive study of dictation hardware, we procured an endless loop dictation system. This new system allows complete "hands free" dictation: no person or paper comes between the individual dictating and the transcriptionist. Since no additional dictation can be recorded once the endless recorders become full,

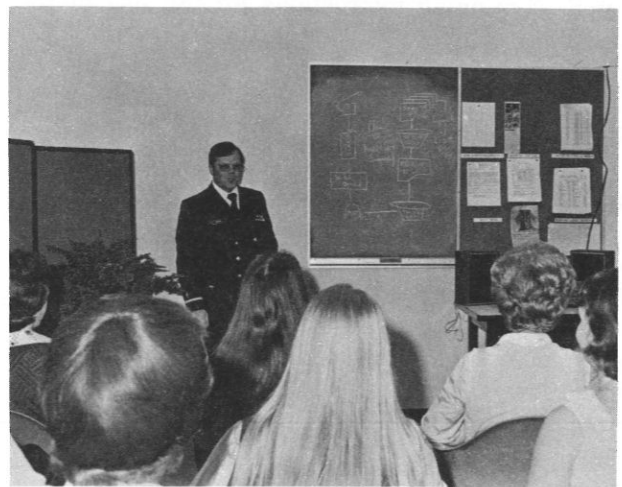
all management efforts, staff, and resources are employed to keep the recorders free of recorded dictation, thus eliminating the possibility of backlogs.

All dictation recording hardware is housed in a small room adjacent to the Word Processing Unit. A false floor was installed in this room, reducing by 20% the time and cost involved in installing the dictation hardware, and providing easy accessibility for maintenance and repair of the dictation recording equipment.

Automatic power typewriters, utilizing magnetic media, were selected to type the transcribed material. These power typewriters offer the transcriptionist increased typing speed and the ability to store prerecorded "canned" material. Finally, an experienced word processing specialist, Mrs. Rosalind B. Raab, was hired to manage the new unit.

To achieve the desired 24-hour turnaround time of all dictated material, additional medical transcriptionists were hired. Two work shifts were created: one during the day and one at night. The addition of the night shift permits the Word Processing Unit staff to transcribe at a time when dictation is at a minimum.

To promote efficiency, several standard forms, such as SF 519, X-ray Request, were redesigned. Pin-feed platens were installed on each power typewriter to accommodate continuous forms. All medical reports are now transcribed in the rough



Word Processing Project Officer ENS A.S. Gesh teaches medical dictation transcriptionists how to use the new equipment.



LT J.R. Steiner (right) and ENS Gesh check the dictation system control panel in the new Word Processing Unit at NRMC Oakland. Through this panel the unit supervisor distributes recorded dictations to transcriptionists.

on single sheets of continuous form paper. The typewritten material is recorded on cassette tapes; the transcriptionist can then back up and type over an error, simultaneously correcting the recording on the tape. The error-free tape is later played out on continuous five-part paper.

The endless loop dictation system is so designed that all information must be dictated. To help physicians learn the requirements of the new system a dictation procedure manual was developed, containing instructions for the use of the dictation equipment and specific instructions for dictating every type of report produced by the Word Processing Unit. Sample copies of all reports produced are included in the manual.

Special reports and controls have been implemented to monitor the production of the Word Processing Unit. Each transcription station is equipped with a meter which tallies the approximate number of words transcribed daily. For a more accurate record of production, a copy of every completed document produced in the Word Processing Unit is forwarded to the Data Processing Service where specific information is keypunched: patient's name, social security number, register and ward number, dictating physician, transcriptionist, type of report, date of dictation, and date of transcription.

From this information the Data Processing

Service generates a "transcription completed" report, a daily alphabetical listing by type of report of every document completed in the Word Processing Unit. A copy of this report is sent to the various users of the dictation system to assist them in determining which reports have been completed. A productivity report, compiled from the data collected to produce the "transcription completed" report, is forwarded to the Word Processing Unit manager to help her evaluate the unit's output and the productivity of the individual transcriptionist, as well as determine the total number of different types of documents completed during the course of the day, week, month, or year.

Dedicated in June 1974, the new Word Processing Unit initially only transcribed inpatient dictation. Two weeks later, the unit's scope expanded to include radiology dictation. In November 1974 the unit assumed the responsibility for transcribing pathology dictation, and in December added a correspondence section which services the various administrative departments throughout the medical center.

During its first 90 days of operation the new Word Processing Unit accomplished its major objective: "a turnaround time of less than 24 hours for routine dictated material."

An ongoing training program has been developed to keep the Word Processing Unit abreast of changes in terminology, technique, and technology in the field of medicine. Once a week, the transcriptionists participate in training sessions conducted by the various clinical services throughout the medical center.

ELEMENTS OF SUCCESS

It is difficult to determine precisely which element in the design of the Word Processing Unit contributed most to its success. Centralization of the word processing function added a new dimension in managerial control. The relocation and interior decorating of the unit created a quiet, physically attractive, and comfortable working environment. Selection of an endless loop dictation system resolved major problems associated with the system's dictation hardware, while installation of power typewriters increased the individual productivity for each employee. The hiring of a professional word processing manager reduced the span of management control and

placed the supervision of the Word Processing Unit staff in the hands of a specialist. Data Processing Service productivity reports provided a dimension of workload measurement and management control never before available. The redesigning of forms and streamlining of procedures expedited the flow of work through the unit. The ongoing training of the Word Processing Unit personnel greatly improved the quality of medical dictation.

Since medical transcription offers few opportunities for career advancement, every effort has

been made to provide employees with a pleasant, comfortable working environment. The personnel of the Word Processing Unit have developed a strong sense of belonging and pride in their new unit. The high level of employee morale is demonstrated by a very low absentee rate.

The new word processing system is a complete success. Of the accomplishments mentioned in this article, one is paramount: the new Word Processing Unit has accomplished its objective of providing 24-hour turnaround time of all dictated material. 📞

RUSH JOB



With an eye toward upcoming Bicentennial celebrations, the statue of Dr. Benjamin Rush, located on the grounds of the Bureau of Medicine and Surgery, has taken on a new glow. Unveiled and dedicated in 1904, the slightly more than life-size statue honors the distinguished American physician who was a signer of the Declaration of Independence. Putting a shine on BUMED's Big Ben is Willie Mobley, an employee of Architectural Metal Maintenance, Inc., of Alexandria, Virginia. (Photo by HM2 Garry Silk, USN.) 📞

WAIVER OF PHYSICAL STANDARDS

Physical standards for initial entry into the Navy and Marine Corps may be waived by line authorities when recommended by the examining physician and concurred in by BUMED. The actual waiver statement is then usually placed in the individual's Personnel Record, *not* the Health Record. Thus Medical Department personnel may not be aware that a waiver has been granted.

BUMED's waiver recommendation policy is flexible, based on feedback measuring the current validity of that policy. For this reason, MANMED 18-20 requires BUMED review of Medical Board reports recommending separation for a condition which had been waived for entry.

To help maintain the consistency of this program, medical officers are urged to make a note in the Sick Call Record (SF-600) when they become aware that a waiver has been granted for a given condition. Patients should be asked specifically whether a waiver was granted when the presenting condition probably existed prior to entry.

NGDS BECOMES NNDC

Effective 1 July 1975, the Naval Graduate Dental School was redesignated the *National Naval Dental Center*.

USE OF NUVA-LITE ACTIVATOR SUSPENDED

The Bureau of Radiological Health of the Food and Drug Administration has notified the L.D. Caulk Company that its Nuva-Lite Activator, used for hardening restorative plastics, proposes a health hazard to dental personnel and patients. The original problem of unnecessary emission of ultraviolet light was thought to have been eliminated in March 1975 through use of additional inserts in the louvers and quartz rod; however, several subsequent cases of eye irritation and minor burns to the face and lips precipitated additional investigation which identified a new area of radiation leakage. The L.D. Caulk Company has been directed to temporarily suspend sales and distribution of the Nuva-Lite, notify all purchasers to stop using the instrument, and correct all devices now in use.

A type I suspension of the Nuva-Lite was recently sent to all ships and stations via an ALNAV directing dental personnel to discontinue use of the instrument. Further instructions and reporting requirements will be forthcoming in the *Naval Materiel Support Command Medical and Dental Materiel Bulletin*.

AERO-MEDICAL CLEARANCE NOTICES

The Manual of the Medical Department requires that all personnel in a flying status be issued an aero-medical clearance notice before they participate in flying duties. To help squadron operations officers anticipate requirements for physical examinations or physiological training, it is recommended

that the expiration date be typed on all aero-medical clearances. This date will normally be the earlier of either the individual's next birth date anniversary, or three years from the most recent physiological training.

FLIGHT SURGEON RESPONSIBILITY

Special attention must be given to insuring proper medical review of aircrewmen before they return to flight duty after an illness. Specific practices to be avoided include pre-dating of up-chits, terminating grounding notices on the initial visit to sickcall, and delegating responsibility for issuing up-chits to nonmedical personnel or to personnel not trained as either flight surgeons or aviation medical officers. Supervising flight surgeons must take immediate action to correct these unsafe practices wherever discovered.

DENTAL CORPS CORRESPONDENCE COURSES

Eligibility for enrollment in the course, "Preventive Dentistry," NAVEDTRA 13115, has been extended to qualified dental enlisted personnel in pay grades E-5 and above who are recommended by their commanding officers. The course provides a clear understanding of the rationale, principles, and current procedures involved in preventive dentistry.

ADMINISTRATIVE WATCH OFFICER'S GUIDE

NRMC Long Beach, California, recently published a comprehensive Administrative Watch Officer's Guide that is full of concise, easy to find, and pertinent information on virtually any situation likely to occur during an administrative watch officer's tour of duty. Such diverse subjects as child abuse, fire alarms, animal bites, ambulance dispatching, rape examination, disasters, drug abuse, deaths, power failure, riots, bomb threats, and the news media are addressed.

Commanding officers of naval medical facilities are encouraged to explore possible adaptation and use of this publication. Contact the CO, NRMC Long Beach, California 90801, for further information.

NAVY TOXICOLOGY UNIT GETS TOXLINE

Procurement of TOXLINE services has been approved for the Navy Toxicology Unit, National Naval Medical Center, Bethesda, Maryland. Through TOXLINE, Medical Department personnel will have access to an extensive collection of computerized toxicology data assembled by the Toxicology Information Program of the National Library of Medicine.

AUGUST ANNIVERSARIES

63rd Anniversary . . . Dental Corps . . . established 22 August 1912

28th Anniversary . . . Medical Service Corps . . . established 4 August 1947

133rd Anniversary . . . Bureau of Medicine and Surgery . . . established by an Act of Congress approved 31 August 1842. 🇺🇸

Malignant Neoplasms of the Small Bowel: Failure of Early Diagnosis to Improve Prognosis

LCDR Dale W. Oller, MC, USN

LCDR Charles L. Rice, MC, USN

Although uncommon, malignant neoplasms of the small bowel are challenging to diagnose and treat. The incidence varies from .02% to 6% of all gastrointestinal neoplasms, with an average of 1.5% (1,3,13). Even though the small bowel comprises 70% to 80% of the length of the gastrointestinal tract, there are 14 gastric and 46 colonic malignancies for each small bowel malignancy (8). This is even more remarkable when the total surface of these organs is contrasted.

Primary carcinoma of the jejunum was reported in the early 18th Century (15). Since then, a number of reports have described experience with the presentation, treatment, and outcome of these lesions (1,2,3,13,16,17). In contrast, metastatic tumors of the small intestine are *not* widely discussed. Diffuse terminal carcinomatosis is common, but solitary or multiple lesions affecting this region are unusual (19).

Many articles report poor prognosis associated with small bowel malignancies (1,2,3,5,9,10,13).

Most authors have cited the lengthy interval between the onset of symptoms and the time of diagnosis, and have attributed this interval, at least partially, to the vague and frequently minor presenting symptoms.

We reviewed ten patients with malignant neoplasms of the small bowel who presented to the National Naval Medical Center, Bethesda, Maryland, from April 1970 to July 1973. (During this period, there were 48,805 admissions to the hospital.) Since these patients all had ready access to medical care without regard for cost, diagnostic studies, hospitalization, or loss of income, they might be expected to seek care soon after the onset of symptoms. The result of such early care has been evaluated for its effect on the outcome.

CASE MATERIAL

The microscopic diagnoses in this series of patients included leiomyosarcoma (three cases), adenocarcinoma (two cases), carcinoid, angiosarcoma, reticulum cell sarcoma, Burkitt's lymphoma, and metastatic melanoma.

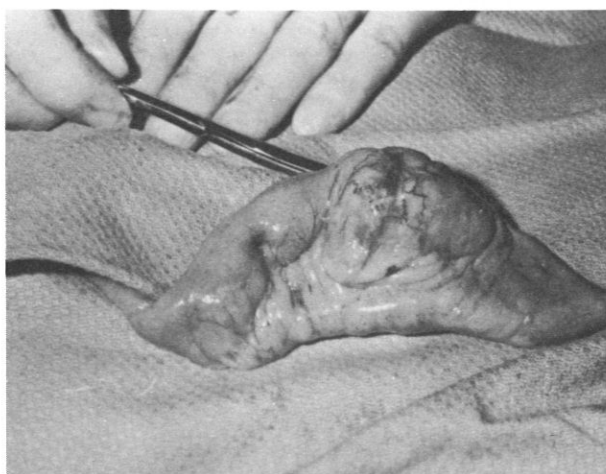
The age range was 14 to 74 years, with a mean of 40 years. Most reports show a predominance of patients in their fifth and sixth decades of life (3,13,16). In our group the patients with Burkitt's lymphoma and reticulum cell sarcoma were

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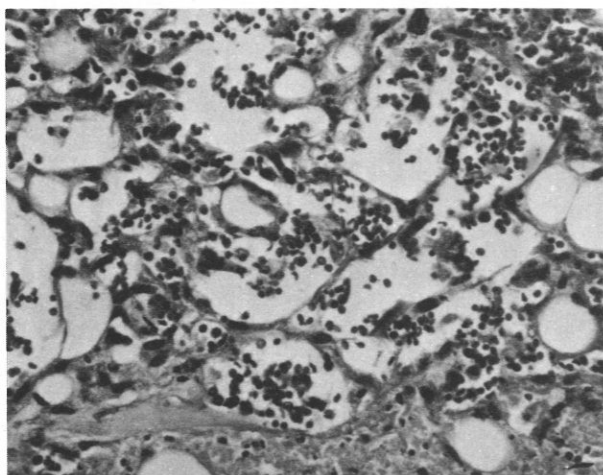
Formerly with the Department of Surgery, LCDR Rice is now a member of the staff of the Division of Experimental Surgery, Naval Medical Research Institute, Bethesda, Maryland.



CASE 1. Angiosarcoma arising from the mesenteric surface of the jejunum.



CASE 3. Carcinoid, ileum.



CASE 1. Angiosarcoma demonstrating vascular sinusoids (x 250 hematoxylin and eosin).



CASE 7. Photomicrograph of Burkitt's lymphoma demonstrating diagnostic "starry sky" pattern (x 250 hematoxylin and eosin).

younger than the sixth decade predominance reported by Naqvi (11) and Loehr (7) for lymphoma. Herlitzka (6) presented ten children with Burkitt's lymphoma with a mean age of seven years.

The sex distribution was nine males and one female. The literature indicates equal incidence. All our patients were Caucasian.

Five of ten lesions involved the ileum. The leiomyosarcomas were duodenal and jejunal. Leiomyosarcomas, lymphomas, and adenocarcinomas appear throughout the small intestine, apparently without predilection as to region. This is in contradistinction to carcinoid, which Sanders (14) reports occurs eight times more frequently in the ileum than jejunum.

SUMMARY OF PATIENTS WITH MALIGNANT NEOPLASMS OF SMALL BOWEL
NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD.
APRIL 1970-JULY 1973

CASE:	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>	<u>9</u>	<u>10</u>
INITIALS:	E.F.	G.R.	M.D.	W.M.	W.L.	V.D.	J.H.	R.C.	R.L.	A.B.
AGE:	47	18	36	74	58	48	14	28	37	68
SEX:	F	M	M	M	M	M	M	M	M	M
DIAGNOSIS:	Angiosarcoma	Leiomyo- sarcoma	Carcinoid	Metastatic melanoma	Leiomyo- sarcoma	Adeno- carcinoma	Burkitt's lymphoma	Reticulum cell sarcoma	Adeno- carcinoma	Leiomyo- sarcoma
LOCATION:	Diffuse	Duodenum	Ileum	Jejunum and ileum	Jejunum	Ileum	Diffuse	Ileum	Jejunum	Duodenum
ANEMIA:	Yes	Yes*	Yes*	Yes*	No	Yes	Yes	No	Yes	No
ABDOMINAL PAIN:	Yes*	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No
OBSTRUCTION:	No	No	No	No	No	Yes*	No	No	No	No
MASS:	No	Yes	No	No	Yes*	No	Yes*	No	No	Yes
WEIGHT LOSS:	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
X-RAY POSITIVE:	No	Yes	No	Yes	No	Partial small bowel obstruc- tion	No	Yes* Mediastinal mass	Yes	No
DURATION OF SYMPTOMS:	6 months	1 month	3 months	6 months	4 months	6 months	1 month	3 months	4 months	1 month
SURGERY:	Biopsy	Curative resection	Curative resection	Palliative resection	Curative resection	Palliative resection	Biopsy	Staging laparot- omy; resection	Curative resection	No operation
COURSE:	Died ninth day postop	Alive with- out evi- dence of tumor, 2 years	Alive with- out evi- dence of tumor, 1 year	Alive with recurrent occult G.I. bleeding	1 year post- op with tumor	4 months postop with tumor	Died sixth postop day	3 months postop with tumor	Alive with- out tumor	Expired pre- op of myo- cardial in- farction

*Presenting Symptom

Anemia and abdominal pain were the most frequent symptoms. Hematocrits of 30% or less were present in five patients, and anemia the presenting sign in four cases. Abdominal pain was present in seven of the ten patients, although it was the presenting symptom in only one case. A palpable mass was present in four patients and was the admitting complaint of two. All patients, except the one with carcinoid, had significant weight loss.

The average duration of symptoms was four months. It is reported that symptoms are virtually absent until significant complications develop (9); even then symptoms may be vague and nonspecific. Hancock (5) reports a duration of 11 to 12 months from onset of symptoms to time of diagnosis.

Nine of our patients underwent laparotomy: two had biopsy only, four had resection for cure, and three underwent palliative resection. The two patients who underwent only biopsy died in the early postoperative period. Of the four patients who underwent curative resection, three are alive without evidence of tumor from 4 to 24 months after surgery. All patients who underwent palliative resection were treated for metastatic or recurrent disease.

Early diagnosis currently offers the only plausible hope for better results in treating these diseases. However, the mildness and lack of specificity of the early symptoms make it unlikely that patients will ever seek help early enough after onset, even in the absence of financial worries, to improve their chances of survival to any significant degree. The paucity of early physical signs also makes it unlikely that routine physical examination will be very helpful.

It seems more likely that substantially improved treatment for small bowel malignancies will come with the development of new diagnostic methods, including techniques for examining the systemic biochemical, endocrine, and immunologic responses to a hidden tumor. Because of the rarity of these particular tumors, and the absence of an identifiable high-risk group of patients, any proposed test must be capable of broad application at reasonable cost and convenience.

Until the means are found for prevention, a vigorous investigation of symptoms and prompt clinical application of new approaches developed in research laboratories will continue to offer the only possibility for relief from malignancies which grow silently in inaccessible places.

SUMMARY

Ten recent cases of small bowel malignancies presenting at NNMC, Bethesda, Maryland, have been reviewed.

1) Weight loss, anemia, and obstruction are common presenting symptoms of small bowel tumors. Because these symptoms are nonspecific, there is often a lengthy interval between their onset and diagnosis.

2) Surgery is usually palliative.

3) Earlier diagnosis in symptomatic patients may not promise a better outcome.

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SCHOLARS' SCUTTLEBUTT



AN ORGANIZATIONAL PLAN FOR NAVY SUBSIDY STUDENTS

The Ensign 1975 scholarship program sponsors the medical undergraduate education of approximately 1,050 medical and osteopathic students throughout the country. Although an educational effort of like magnitude has not been undertaken in the past 25 years, this endeavor has worked well in the short interval since its inception.

At present, however, our students are isolated both from the mainstream of Navy medicine, and also from each other. In my experience, it took many months before the identity of fellow naval scholars became known. While the situation is much better in the few schools that have a large contingent of Navy students, there is still no communication among students at different schools.

An organization of Navy medical and osteopathic ensigns would open up new channels of communication. Varied and valuable summer experiences, including cruises and clerkships, could be shared. Navy graduate medical education policies could be explored. An even greater advantage would be the development of a Navy community with its inherent esprit de corps. The Navy system of health care delivery and its educational opportunities could be more attractively presented to our civilian counterparts.

Informal groups of this type have been established at several medical schools. While these informal groups are commendable, they possess inherent disadvantages. First, they have no unified objectives. Second, they are not linked to the Bureau of Medicine and Surgery, and are therefore unable to disseminate accurate information and current policy.

Because of the need for better and more available channels of communication, I propose the establishment of *Committees of Correspondence*, made up of the Navy medical and osteopathic students at each school. The elected chairmen of each committee would be responsible for communication with the Subsidy Division of the Health Sciences Education and Training Command.

Corresponding committees may be the most advantageous unit of organization for many reasons. First, they would ensure that directives are fully distributed. Second, they would encourage local understanding and support of Navy policy decisions. Third, they would allow all students to be consulted quickly regarding program management. Fourth, they would provide a framework to express student needs. Fifth, they would establish the nucleus of a Navy organization at each medical and osteopathic school.

A logical extension of the committee structure would be an annual meeting of committee chairmen with representatives of the Health Sciences Education and Training Command, clinical and research programs, operational medicine, and the Bureau of Medicine and Surgery. Such a meeting would provide an opportunity for program directors and students to exchange ideas about Navy Medical Department activities; it would also provide a valuable opportunity for program directors to gauge student opinion concerning their professional development. Such an exchange would be of value in the formation of policy regarding Navy subsidy programs.

The Committees of Correspondence concept is proposed in the belief that it could be the basis of understanding between program managers and participants whose mutual goals include the continued delivery of the highest professional standard of Navy health care. Your thoughts and ideas are encouraged. Send your comments to the Editor, U.S. Navy Medicine, Department of the Navy, Bureau of Medicine and Surgery (Code 0010), Washington, D.C. 20372. — ENS Samuel A. Forman, MC, USNR. 🍀



NAVY MEDICINE — 1875

EUROPEAN STATION. Surgeon Thomas C. Walton reports upon his meeting with Professor Caesar P.M. Boeck (1845-1913), "the celebrated syphilographer" and dermatologist, at the Royal Hospital, Christiania, Norway:

The service of venereal and cutaneous diseases is in charge of the venerable Professor Boeck. He honored Assistant Surgeon Rogers of this vessel [USS *Juniata*] and myself with a minute description and illustration of his method of treating syphilis, and exhibited to us most of his hospital patients, about 100, who were being subjected to it. It would be superfluous to describe the *modus operandi* of the treatment of syphilis by syphilization, particularly after the publication of Bumstead's report on Professor Boeck's treatment of two cases in New York during his recent visit to the United States. The professor states that those two cases and their limited time of treatment were not sufficient to enable any one to form a correct estimate of the value of the method. He claims for syphilization that it is applicable in nearly every case of syphilis, and that the chances of future manifestation of the disease are more diminished by that method of treatment than by any other; that the diminution is decided, the number of cases of relapse being very few, seldom occurring where syphilization has been the only treatment adopted and where it was resorted to on the first appearance of constitutional symptoms. This he believes to be proved in the "tables of statistics, taken from the archives of the hospitals of Christiania," appended to his recently published "Researches upon Syphilis," a copy of which I was favored with, but have not yet been able fully to peruse. It is a history of cases of syphilis treated in Christiania during the past fifty years by various methods, including syphilization. So far as a single visit to this interesting service would indicate, the professor seemed to have good reasons for his faith. His patients were of every age from

the nursing infant to the sexagenarian, and every stage of syphilis was represented by them; all were being treated by syphilization, and all except two appeared to be progressing favorably; the exceptions were an old case of lupus and a case complicated with erysipelas, of whom it was whispered that the complication was due to impure inoculation. None of the patients were anaemic or depressed in appearance, and to none had tonics been administered nor other than ordinary hospital diet. Syphilization was never commenced until after the appearance of secondary symptoms; occasionally when it appeared to act unfavorably or to be inert, mercurials or potassii iodidum would for a time be resorted to and afterwards inoculation carried to the complete cure. Treatment generally extended over four months when commenced with the early symptoms of the disease; a longer period was often required when the disease was of long standing.

The professor appeared very desirous to prove to us the efficacy of the method; he invited me and any of my friends to send him at any time the worst and most intractable case of syphilis we could find for treatment, and he would all but guarantee a cure. He also remarked that syphilization was approved by the patients and people of Norway, generally, who knew aught of it; that on his return from America, after he had resigned his position in the hospital and University, he had been invited to resume charge of the syphilitic and cutaneous department, when his length of service entitled him to rest, showing the confidence of the people in the system he advocated and practiced.—*Hygienic and Medical Reports by Medical Officers of the U.S. Navy*, prepared for publication, under the direction of the Surgeon-General of the Navy, by Joseph B. Parker, A.M., M.D., Surgeon, U.S. Navy, Assistant to the Bureau of Medicine and Surgery. Washington: Government Printing Office, 1879, pp. 72-74. 🐼



PRESIDENT FORD JOINS GROUNDBREAKING CEREMONIES FOR USUHS

President Gerald R. Ford turned the first shovel of earth on 10 July 1975 in groundbreaking ceremonies for the first building of the new Uniformed Services University of the Health Sciences. The President addressed a gathering of dignitaries, officials, and friends of the University, and joined the Secretary of Defense, Congressional leaders, and University officials in breaking ground for the new medical school. The ceremonies were held on the grounds of the National Naval Medical Center, Bethesda, Maryland.

The \$15 million classroom-laboratory building is the first of several USUHS buildings planned for construction over the next six years. It will contain approximately 170,000 square feet of floor space.

The University was established by an Act of the 92nd Congress, 21 September 1972. It is a separate agency of the Department of Defense, with authority flowing directly from the Secretary through the Board of Regents to the University president. Chairman of the Board of Regents is former deputy secretary of defense David Packard. University president is Anthony R. Curreri, M.D.

The University will be located on a 90-acre campus on the southeast corner of the grounds of the National Naval Medical Center. The first class of medical students will be admitted in the fall of 1976, and will be housed temporarily at the Armed Forces Institute of Pathology at Walter Reed

Army Medical Center, Washington, D.C.—
OASD(PA).

OAKS ACROSS THE SEA

In a gesture of goodwill VADM D.L. Custis, Navy Surgeon General, recently presented to his British counterpart, Medical Director General (Naval), Surgeon VADM Sir James Watt, three oak tree saplings for planting in Royal Navy



Surgeon RADM G.A. Binns, medical officer in charge at Royal Naval Hospital Plymouth, England, and LCDR James Schultz, USN plant an oak sapling presented to the Royal Navy by VADM D.L. Custis.



Surgeon RADM J.S.P. Rawlins, medical officer in charge and dean of medicine at the Institute of Naval Medicine, Alverstoke, Hampshire, England, watches as Mrs. Carol Vorosmarti plants an oak sapling from BUMED on the grounds of the Institute.

medical establishments. The saplings were grown in the United States from the acorns of an oak tree at the Bureau of Medicine and Surgery, Washington, D.C. Although not positively identified, the tree at BUMED is thought to be of Japanese origin, and to have been brought to the United States by Commodore Matthew Perry in 1854.

The saplings were planted on the grounds of the Royal Naval Hospital Plymouth, Royal Naval Hospital Haslar, and the Institute of Naval Medicine, Alverstoke, where they stand as testimony to the close relationship between the Medical Departments of the Royal Navy and the U.S. Navy. 🇺🇸

CHAMPUS IMPLEMENTATION

Department of Defense Directive 5105.46 of 4 December 1974 establishes the Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) under the policy guidance and operational direction of the Assistant Secretary of Defense (Health and Environment), and assigns to that office responsibility for the

supervision and administration of the OCHAMP-US mission worldwide.

To implement this directive the following actions were effective 1 July 1975:

The Office of CHAMPUS, Europe (OCHAMPUSEUR) was transferred from the Department of Army to OCHAMPUS. All personnel, funds, files, equipment, and other resources were included in this action, and the head of OCHAMPUSEUR became acting director of the new office. Administrative and logistic support will be provided by the Department of the Army. The responsibilities of OCHAMPUSEUR were unchanged, except that, as authorized by Title 38, U.S.C., Section 613, it will now process claims for care provided on or after 1 July 1975 to spouses and dependent children of totally disabled veterans, or of veterans who have died as the result of a service connected disability.

A sub-office of OCHAMPUS will be established in CHAMPUSSO (Bermuda, West Indies, Central and South America, and Mexico), and CHAMPUSPAC (Pacific Command exclusive of Hawaii). All claims for care furnished to eligible beneficiaries in these areas on and after 1 July 1975 should be submitted to:

CHAMPUSSO— Mutual of Omaha
Insurance Company
3301 Dodge Street
Omaha, Nebraska 68131

CHAMPUSPAC—Hawaii Medical Service
Association
P.O. Box 860
Honolulu, Hawaii 96808

All requests for prior approval of care for these two areas, for either the Basic Program or the Program for the Handicapped, will be forwarded directly to OCHAMPUS, Denver.—OASD(H&E). 🇺🇸

DENTAL EXHIBIT PLANNED

Members of the Joint Armed Forces Dental Exhibit Committee are completing plans for production of the FY 1976 exhibit, "Diagnosis of Oral Lesions." The exhibit is scheduled to be displayed for the first time at the 116th Annual Session of the American Dental Association in Chicago, 26-30 October 1975.

This exhibit will present the clinical appearance

of a lesion or radiograph, while simultaneously providing the diagnosis and a brief description of the case. A second section of the exhibit will contain a series of black-lighted transparencies showing the clinical appearance of a lesion, a radiograph, laboratory tests, and histology. Viewers can control the light that illuminates the last transparency—the diagnosis.

The exhibit is also scheduled to be displayed at the Greater New York Dental Meeting in New York City, 30 November-4 December 1975.—BUMED Code 6. ☞

NAVY BLOOD PROGRAM AIDS ST. JUDE CHILDREN'S RESEARCH HOSPITAL

In November 1972, an agreement was signed between NH Memphis and the nearby St. Jude Children's Research Hospital, enabling the staff at St. Jude's to harvest platelets from whole blood donated at the NAS Memphis Blood Donor Center. Since the inception of the program one



LCDR J.R. Beene receives a plaque from entertainer Danny Thomas in recognition of the naval officer's role in providing blood platelets to St. Jude Children's Research Hospital.

month later, NH Memphis has provided approximately 4,500 platelet preparations to St. Jude's.

LCDR Joe R. Beene, laboratory officer at the naval hospital, recently received a plaque and letter of appreciation for his role in establishing and supporting the program. The award was presented by internationally famous entertainer Danny Thomas, in town for the Danny Thomas Memphis Classic Pro Golf Tournament.

St. Jude's was founded by Thomas in 1962 as a nonprofit, nondenominational institution for the research, care, and treatment of children with catastrophic diseases. Children are referred to St. Jude's from all points of the United States, and the patients include many military dependents. All patients, regardless of the financial circumstances of their parents, receive care and treatment at no cost.

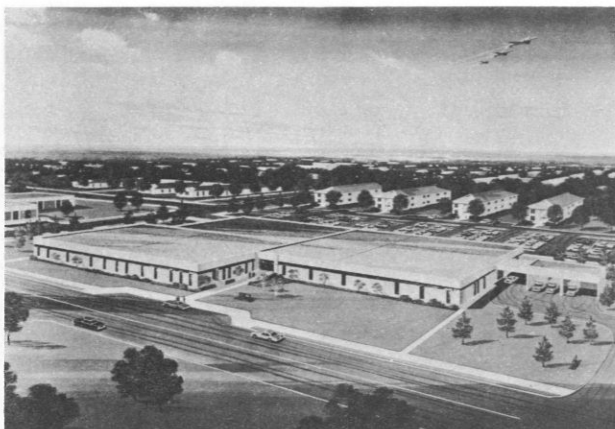
Each year, in addition to lending his name to the golf classic, Danny Thomas sponsors a gigantic entertainment at the Memphis Coliseum to raise money for the hospital. Performers volunteer for the "Shower of Stars" extravaganza. This year more than \$200,000 was raised.

During the performance, Thomas gave recognition to the Navy by introducing CAPT Harry B. Lee, Deputy and Chief of Staff for the Naval Air Technical Training Command, and CAPT Ross M. Lehman, Jr., commanding officer of NH Memphis. The officers were thanked for Navy support to St. Jude's.—PAO, NH Memphis, Tenn. ☞

NEW MEDICAL-DENTAL FACILITY FOR NAS MEMPHIS

Fortec Constructors Inc., a Miami-based firm, has received a \$3,383,000 fixed-price contract for construction of a single building to house a branch dispensary and dental clinic at NAS Memphis, Millington, Tennessee. Construction of the facility is expected to be completed in July 1976.

The brick-faced, concrete-block structure will feature exposed concrete spandrel beams and a built-up roof, and will include 56,000 square feet of floor space. The branch dispensary will hold a pharmacy, laboratory, blood donor center, X-ray and physical therapy facilities, administration offices, environmental and occupational health services, and examining rooms. The dental clinic will house eight modular dental operating rooms, laboratories, X-ray facilities, preventive dentistry facilities, and administration areas.



Artist's conception of the new branch dispensary and dental clinic now under construction at NAS Memphis.

The dispensary serves an active-duty military population of more than 12,000 men and women, while the dental clinic provides treatment to eligible dependents and retirees in addition to all active-duty personnel.

According to RADM A.M. Sackett, chief of Naval Technical Training, new facilities have been needed for a long time, "not merely to replace the old, but to accommodate the growing population. The dispensary and dental clinic will now be in one building located near the highest concentration of those needing the services."—PAO, NAS Memphis, Millington, Tennessee.

NAVAL AEROSPACE PHYSIOLOGY TRAINING DEVICE PROGRAM

The Naval Aerospace Physiology Program is designed to indoctrinate and train aviation personnel in the physiological stresses of the aerospace environment. The Naval Training Equipment Center, Orlando, Florida, has been tasked by the Naval Education and Training Command to support the Bureau of Medicine and Surgery in providing necessary training aids and devices.

An aerospace physiologist is currently assigned at the Naval Training Equipment Center as project director on new procurement of aerospace physiology training devices. Responsible for matching the needs of the fleet with specifications for developing training devices, he also coordinates

requests from industry for bid packages, conducts proposal evaluations, and helps ensure that contracts are appropriately awarded. The responsibility of the physiologist continues through design and progress review meetings, delivery, and final acceptance of the training device by the fleet.

The Naval Training Equipment Center recently procured, under contract, a high altitude rapid decompression chamber for installation in the new naval hospital at Corpus Christi, Texas. Fourteen universal ejection seat trainers are in the final stages of delivery and acceptance testing. Most recently, six flash blindness and visual problem simulators were procured after the device prototype was inspected by the Naval Training Equipment Center technical team and a BUMED fleet project team in November 1974. To date, some 87 aerospace physiology training devices and simulators are under procurement or in various stages of logistic support.

A specialty code has been established to review and implement modification requests from fleet activities. This specialty code is billeted as acquisition director for aerospace physiology training device modifications, and is presently manned by an electrical engineer with 14 years'



LCDR Monty Herron, aerospace physiologist, and Mr. Hans Windmueller of the Naval Training Equipment Center examine the engineer's control panel for Device 9A2A, Mobile Rapid Decompression Chamber.

experience with medically oriented training devices.

Current modification programs include the conversion of two mobile low-pressure chambers into environmentally controlled rapid decompression chambers that can be transported anywhere in the world and be completely operational within 48 hours. Another modification program dealing with rapid decompression chambers will increase intermediate lock capabilities to create environments similar to those that occur when a transport aircraft loses cabin pressurization. Upon completion of the modification program, all Navy decompression chambers will be equipped with highly reliable digital altimeters and rate-of-climb indicators, giving instructors the options of manual or programmed automatic control of the training device.—LCDR D.M. Herron, MSC, USN, Naval Training Equipment Center, Orlando, Florida. 🇺🇸

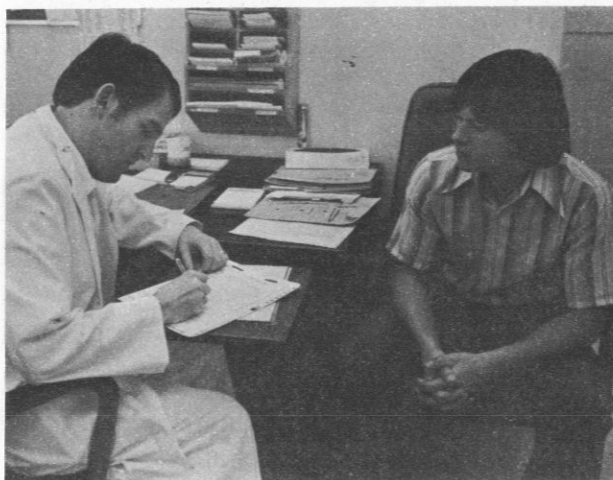
THE ADOLESCENT CLINIC AT A MILITARY TEACHING HOSPITAL

To meet the medical needs of teenage dependents of military personnel, an Adolescent Clinic was opened at NRMCC Oakland, California, in the spring of 1974 under the direction of the chief of the Pediatric Service, CAPT James W. Hayes, and CDR Frank J. Gareis, who heads the clinic. The clinic has been enthusiastically received by the patient population it was designed to serve.

Located in an old but fully refurbished structure which formerly served as a medical ward, the



Youths from 13 to 18 years of age are now served by their own Adolescent Clinic at NRMCC Oakland, California.



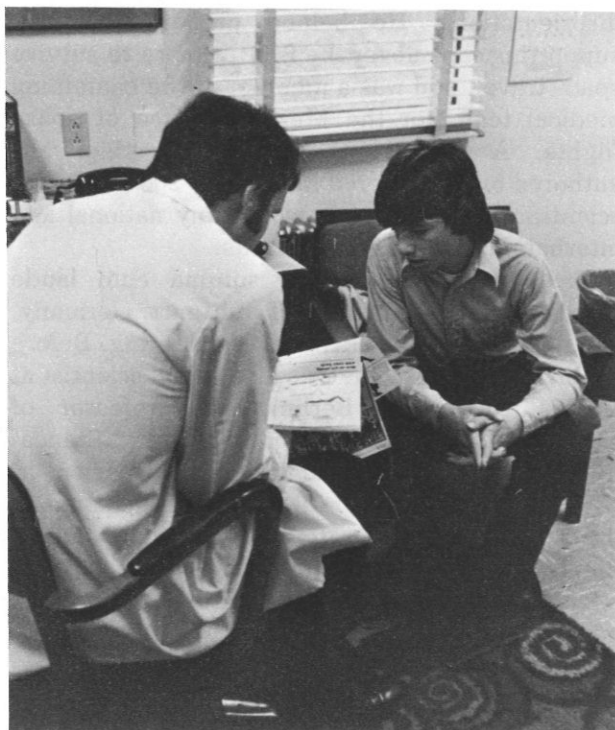
LT Quentin VanMeter (MC) records the medical history of a 17-year-old patient. A comfortable, personal relationship develops between teenager and pediatrician when the young patient knows he is receiving special attention in his own clinic.

Adolescent Clinic stands apart from the main hospital complex yet is within easy walking distance of the hospital's radiology, laboratory, and pharmacy facilities.

The hours of clinic operation coincide with regular working hours, Monday through Friday. The Adolescent Clinic has a staff of two pediatricians, one with subspecialty training in adolescent medicine; pediatric residents also rotate through the clinic. There are approximately 150 to 175 patient visits per week. When hospitalization is indicated, patients are admitted to the Pediatric or Internal Medicine Service, according to their maturity. Since the incidence of serious morbidity has been low, an adolescent inpatient ward has not yet been required.

Adolescent medicine can be described as "general practice for an age group," and the Oakland clinic has made special efforts to provide the best, most comprehensive care for these patients. In addition to health maintenance and concerns dealing with acute health care issues, regular subspecialty and consultation clinics are held in orthopedics, obstetrics and gynecology, endocrinology, cardiology and neurology. Weekly staff conferences are also conducted with child psychiatry consultants.

The presence of these important referral clinics insures that the pediatrician in the Adolescent Clinic remains a primary care provider. This



LCDR Forrest Beaty, MC, USNR explains a series of back exercises to a 16-year-old patient.

centralization of responsibility emphasizes that the clinic is prepared to meet virtually all of the young patient's health care needs.

The goals of the NRMCC Oakland Adolescent Clinic are similar to those of adolescent clinics elsewhere: to provide comprehensive health care for a population which is often medically overlooked; and to help the patient with the complex psychosocial problems which often come into focus during adolescence.

Plans are under way to obtain recognition for the adolescent medicine program to permit post-graduate fellowship training in this field to be offered to interested and qualified physicians from other medical commands throughout the Navy. In the meantime, the clinic helps meet the complex health care needs of its young patients, and trains physicians in the fine craft of caring for youth. — PAO, NRMCC Oakland, Calif. 🍀

LCDR CALL QUALIFIES AS TEST PARACHUTIST

LCDR Douglas W. Call (MSC), aerospace physiologist at the Naval Aerospace Recovery

Facility, El Centro, California, recently qualified as a Navy test parachutist. To obtain this qualification he used himself as a subject while measuring the physiological stresses a novice jumper experiences during test parachutist training.

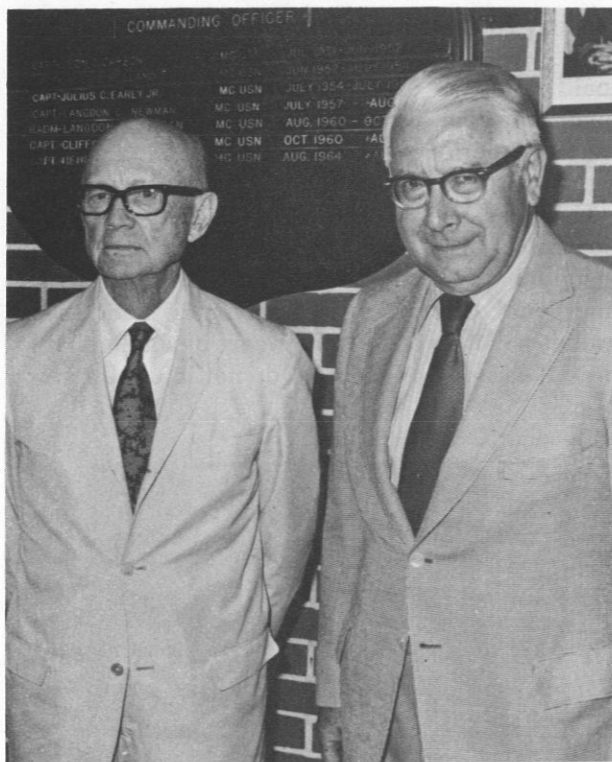
The Bureau of Medicine and Surgery sponsors biomedical research programs at El Centro designed to study human factor aspects of emergency aircraft egress. Results from these studies will help design engineers develop reliable aircraft escape systems that do not injure aircrewmembers.



Aerospace physiologist LCDR D.W. Call has qualified as a Navy test parachutist. 🍀

TWO NAMRL CIVILIANS HONORED

Two high-ranking employees at the Naval Aerospace Medical Research Laboratory, Pensacola, Florida, have received special recognition from Secretary of the Navy J. William Mendenhall II, in ceremonies conducted by CAPT Newton



Ashton Graybiel, M.D. (left) and Dietrich E. Beischer, Ph.D., two high-ranking civilian employees at the Naval Aerospace Medical Research Laboratory, have been honored for outstanding contributions to the Navy Department.

W. Allebach (MC), NAMRL commanding officer. In recognition of their contributions to the Navy Department, inscribed certificates and emblems of Navy civilian executive status were presented to Ashton Graybiel, M.D., special assistant for scientific programs and head of the Biological Sciences Department, and to Dietrich E. Beischer, Ph.D., chief of the Biomedical Sciences Division. The certificates and emblems are symbols of the unique status of civilian executives who serve side-by-side with their military counterparts.

A cum laude graduate of both the University of Southern California and Harvard University School of Medicine, Dr. Graybiel came to Pensacola in 1942 from Boston, where he had been in practice with the late renowned heart specialist Paul Dudley White, M.D. A veteran of 33 years of federal service (he retired as a Navy captain after 26 years of service), Dr. Graybiel has worked in aviation medicine and related medical fields, contributing to the prevention of aircraft accidents resulting from vertigo or

disorientations. He helped prepare the life-supporting capsule for the first primate to survive space travel, and was a member of the examining medical team for the Mercury series of space flights. A prolific writer, Dr. Graybiel has authored or co-authored more than 200 published scientific works, and has won many national and international honors and awards.

Dr. Beischer is a 1932 summa cum laude graduate of the University of Stuttgart, Germany, and holds a Ph.D. in chemical engineering. Before coming to Pensacola he was a research scientist at Dozent University, Berlin, and professor of chemistry at the University of Strasbourg, France. Chief of the Biomedical Sciences Division at NAMRL since 1947, Dr. Beischer participated in the planning, preparation, monitoring during flight, recovery, and subsequent analyses of telemetered data on the first ventures of primates into outer space.

Dr. Beischer's research interests are in aggregation of matter from molecular state, behavior of matter under extreme environmental conditions, electronmicroscopy of ultra-fine structure of matter, and living tissue. His latest research project deals with non-ionizing radiation.

A former vice-president of Aerospace Medical Association, Dr. Beischer has 75 publications to his credit in American and German journals, 25 in the field of bioastronautics (ballistic missile flights of monkeys Able and Baker, Mercury Project, gravity-free flight in airplane, biomagnetics). Among his many awards is the Arnold D. Tuttle Award for original research and the most significant contributions toward solving a challenging problem in aerospace medicine.—PAO, Naval Aerospace and Regional Medical Center, Pensacola, Florida. ☸

CAPTAIN MOORE TEACHES IN GUATEMALA

CAPT Dorsey J. Moore (DC), chief of the Maxillofacial Prosthetics Division, National Naval Dental Center, Bethesda, Maryland, recently presented what is believed to be the first course in maxillofacial prosthetics offered in Guatemala. In addition to lectures and clinics, he treated patients at the University of San Carlos, Roosevelt Hospital, Military Hospital, and the Institute of Cancer. He also taught techniques of oral-facial rehabilitation to local dentists, physicians, and

technicians, many of whom were unfamiliar with this dental discipline.

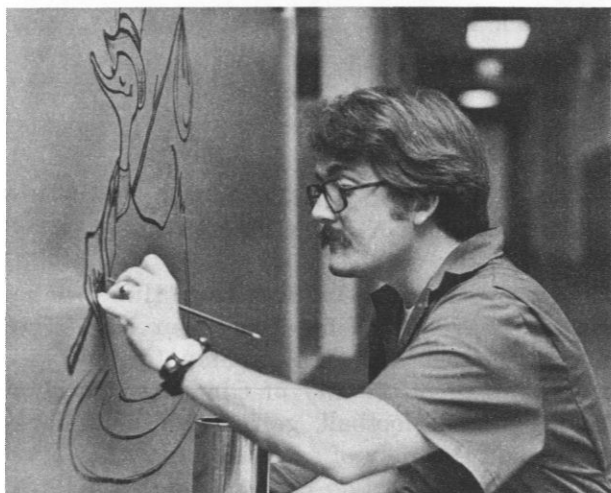
The course of instruction and practical demonstrations were coordinated by the faculty of odontology from the University of San Carlos. The Guatemalan Army and the Institute of Social Security served as hosts for the course.

CAPT Moore participated in the course as an international circuit course lecturer of the American Prosthodontic Society.—PAO, NNMC, Bethesda, Md. ☛

ARTIST ADDS COLOR TO PEDIATRIC WARD

Thanks to the efforts of Mike Willhoite, hospitalization should be a bit less traumatic for patients on the pediatric ward at the National Naval Medical Center, Bethesda, Maryland. A civilian illustrator in the Media Division of the Naval Health Sciences Education and Training Command, Willhoite recently painted 32 famous fairytale characters on the walls of the newly renovated ward. Little Miss Muffett, Old King Cole, and Mary and her little lamb will now help see young patients through their stay in the hospital.

The colorful artwork completed the four-and-one-half month refurbishment of the pediatric ward, during which time a number of improvements were realized. Rooms on the ward were enlarged, and new, larger doors installed to help facilitate the movement of beds and equipment. A central air conditioning system has replaced old window units and the ward has been brightened



ARTIST'S TOUCH. Mike Willhoite adds a friendly face to the walls of the NNMC pediatric ward.

by a suspended ceiling, an improved lighting system, and fresh paint.

New features on the ward include three isolation rooms, served by anterooms where staff members wash and gown before entering the isolation areas. In addition an area has been reserved for adolescent admissions.—PAO, NNMC, Bethesda, Md. ☛

THIRTY YEARS OF SERVICE AND MEMORIES

A barrel of carbide is on fire, and has set off a dozen bombs. There are several casualties. Four barrels of mustard gas close by may explode any minute. Two hundred and fifty war prisoners are pleading with you to be released before the gas becomes lethal. What do you do?

Walter Tarnok, a veteran employee at the Naval Aerospace and Regional Medical Center, Pensacola, Florida, found the answer to this dilemma. In 1945 acting First Sergeant Tarnok was in charge of 250 German prisoners of war in a munitions camp in Achen Hein, Germany. In response to the prisoners' plea he opened the prison gates, ordering the prisoners to a safe place three miles away from the camp. They were told to return the next day at 8 a.m.

After he calmed down, Tarnok started worrying about the consequences of his action. But his fears of a possible court martial disappeared after his commanding officer personally ordered the release of the prisoners. The fire was extinguished without any further casualties, and next morning



Walter Tarnok receives a 30-year service pin, presented by LCDR Donald M. Davis (MSC), chief of Operating Management Services at Naval Aerospace Regional Medical Center, Pensacola, Florida.

Tarnok was surprised by the return of the 250 prisoners.

"In five years of wartime service, including 465 combat days in Africa, Sicily, Palermo, Anzio, France, and Germany, that prison incident was my most harrowing experience," Tarnok remembers. Among his war souvenirs is the Bronze Star, earned for saving an unconscious truck driver and unloading a truckful of artillery shell which was threatened by a box of burning powder following an enemy strafing.

Tarnok, who speaks five languages, was challenged one day at a checkpoint on his return from a mission. Although able to give the correct password (in an unmistakable German accent), he was marched off to the interrogators as a suspected enemy infiltrator. The interrogators became more suspicious when he could not name the capital of Louisiana, his home state. Tarnok recalls that he was so furious and frustrated at being stopped he could not remember the city Baton Rouge; only his strong language and mounting anger finally convinced the interrogators that Tarnok was an American soldier.

A native of Basel, Switzerland, and a graduate of the Horticultural College of Zurich, Tarnok had barely rooted himself in Louisiana when he was drafted into the U.S. Army in 1941. After his discharge from the service, he began working for NARMC in 1948 as a gardener, eventually rising to his present position as assistant housekeeping officer.

Tarnok was recently honored for 30 years of service in an informal ceremony at NARMC.—PAO, NARMC, Pensacola, Fla. 🍀

LCDR RIVIERE HONORED AS OUTSTANDING DENTAL SCIENTIST

LCDR George R. Riviere, DC, USNR, of the Naval Dental Research Institute, Great Lakes, Illinois, was recently honored by the Chicago Section, American Association for Dental Research (AADR), as one of three outstanding dental scientists in the Chicago area. The Association annually recognizes three recent graduates within the Chicago area for scientific achievement in dental research.

LCDR Riviere received the second place award of \$200 for his research paper, "Demonstration of Naturally Occurring Salivary Antibody in Caries-Free Humans Against Serotype c *Streptococcus*

mutans." Coauthors were CAPT William R. Cotton (DC) and DT1 James L. Derkowski.

The paper described a technique developed by researchers at NDRI for demonstrating naturally occurring human antibodies to the bacteria that cause dental caries. The technique was used to identify antibodies present in the saliva from caries-free naval personnel at Great Lakes. Identification of these antibodies in caries-free individuals is an important step in NDRI efforts to develop a vaccine against dental decay.

A dentist and immunologist, LCDR Riviere received his D.D.S degree from the University of Illinois, and his Ph.D. degree from the University of California. He also holds a B.A. degree from Drake University, Des Moines, Iowa.

LCDR Riviere received his award during the annual NDRI-sponsored dinner meeting of the Chicago Section, AADR. The award was made possible by a grant from the William Wrigley Co. of Chicago.



LCDR G.R. Riviere, DC, USNR (left) receives the second place award as outstanding dental scientist in the Chicago area from Dr. Allen Goldberg, Chicago Section, American Association for Dental Research. 🍀

ONE-ARM DOVE HUNT PLANNED IN TEXAS

The Fourth Annual One-Arm Dove Hunt will be held in Olney, Texas, 5-6 September 1975. The hunt is open to any hand or arm amputee, and will include a tour of the city of Olney, a cow chip chunk'n contest, football, golf, a fish fry, a dove dinner, and a variety of social events.

For more information contact: One-Arm Dove Hunt Association, PO Box 582, Olney, Texas 76374. 🍀

OFFICIAL INSTRUCTIONS AND DIRECTIVES

BUMEDINST 6260.18 of 20 May 1975

Subj: Occupational environmental health services

The Medical Department provides Navy commands and activities with needed occupational environmental health services. The overall Navy Occupational Environmental Health Program is planned, directed, and coordinated by the Occupational Environmental Health Division (BUMED Code 56).

COs of naval regional medical centers, clinics, and hospitals shall establish a regional occupational environmental health service as an element of their command, consistent with the guidelines set forth in enclosure (1) to this instruction, and shall provide occupational environmental health services to activities of the operating forces and shore establishment.

The Navy Environmental Health Center shall provide consultation support upon request, and shall inform BUMED of the effectiveness of the Occupational Environmental Health Program.

BUMEDINST 6300.2

Change Transmittal 2 of 20 May 1975

Subj: Medical services and outpatient morbidity reporting system

This transmittal provides page changes for BUMEDINST 6300.2 of 11 June 1971. The requirement is reinstituted for submission of Medical Services and Outpatient Morbidity Reports (NAVMED 6300/1) from individual medical treatment facilities in lieu of reporting by regions. The original copy of the report for each individual naval medical treatment facility within a naval region shall now be sent directly to the CO, Naval Medical Data Services Center, National Naval Medical Center, Bethesda, Maryland 20014. A copy of the report shall also be provided to the appropriate regional medical center for regional use.

Clinics (fixed medical treatment facilities without authorized operating beds) will report vasectomy data in section IV of the report. All

other reporting facilities will continue to report vasectomy data as previously instructed.

Data for optometry and family practice clinic/service will be reported in section VI. Data for genital herpes virus will be reported in section VII.

BUMEDINST 6510.2D of 21 May 1975

Subj: The Armed Forces Institute of Pathology and Armed Forces Histopathology Centers

This tri-service instruction prescribes the organization, administration, and relationships of the Armed Forces Institute of Pathology, Washington, D.C., and describes the centralized services provided by the Institute. It also provides for the designation of certain hospitals and medical laboratories as histopathology centers.

BUMEDINST 6120.22 of 23 May 1975

Subj: Department of Defense Medical Examination Review Board

The Department of Defense Medical Examination Review Board (DODMERB) is a joint agency of the military departments, responsible for scheduling, reviewing, and certifying service academy and ROTC scholarship medical examinations. The Secretaries of the Air Force, Army, Navy, and Transportation, or their designees, provide necessary manpower authorizations, and administrative and technical assistance to the Board.

The DODMERB maintains a file of examining centers, and schedules medical examinations of authorized applicants to service academies and ROTC scholarship programs. Other duties include sending notices of scheduled examinations and medical status determinations, reviewing and applying medical standards to the medical examinations, providing copies of medical examinations on request, and maintaining a file on each applicant.

Medical examinations are carried out at medical examining centers in the U.S. and overseas. The Director, DODMERB determines the need for and locations of such centers.

Each service is represented on the DODMERB by at least one medical officer. Enlisted medical technicians are assigned to assist their service's physician representative. The position of Dental Surgeon is filled on a rotational basis among the services. The normal tour of duty with DODMERB is four years.

BUMEDINST 5726.1B of 28 May 1975

Subj: Navy Community Service Program

The objective of the Navy Community Service Program is to use the extensive resources of the Navy, in cooperation with other governmental and private organizations, to help solve domestic problems and contribute to the constructive development of society. It is the policy of the Chief, BUMED to support this program to the maximum extent possible, within the limits of available resources and provided that such support does not interfere with the mission of the activity.

In addition to medical activity support of the program, individuals are encouraged to participate voluntarily in community service efforts during off-duty hours. Such involvement is especially recommended in community drug, physical and mental health, family planning, and other related medical and dental efforts.

Although annual reports to BUMED are no longer required, activities are urged to keep basic records of their participation in this program.

BUMEDINST 1520.12F of 2 June 1975

Subj: Medical Service Corps full-time training program

This instruction pertains only to BUMED-sponsored, full-time training of Medical Service Corps officers at inservice facilities and civilian education institutions; it supplements MANMED

arts. 7-10 through 7-13, outlining specific policies, curricula, eligibility requirements, and application procedures.

It is BUMED's desire to help all MSC officers to raise their educational level to at least the baccalaureate degree level; however, because of the limited number of billets for full-time training, it is considered more appropriate for officers with 2300 designators to receive such assignments. Assignment of officers to full-time courses of instruction is restricted to a maximum of two years. Officers must agree to serve on active duty after completion of instruction for a period of one year for each half year or fraction thereof of instruction received.

All applications for full-time training shall be submitted via the applicant's commanding officer to the CO, Naval Health Sciences Education and Training Command (HSETC), National Naval Medical Center, Bethesda, Maryland 20014, in accordance with directions and deadlines given in this instruction. Training requests are reviewed by the MSC Advisory Board. Considerations for approval include projected staffing needs of the service, availability of funds, and applicant's academic background, age, experience, performance record, potential career pattern, and availability for training.

Officers who plan to attend the Naval School of Health Care Administration (NSHCA) or the George Washington University are encouraged to avail themselves of the educational counseling service offered by the NSHCA. This counseling service helps to relate the student's prior service and college experience to the curriculum and degree requirements of the training institution, and enables the student to measure progress toward an educational goal. Letters requesting such counseling should be forwarded to the CO of NSHCA, and should include the information called for by this instruction.

Officers who complete full-time training will be assigned to appropriate commands in which they can put to practical use the academic knowledge gained.

All educational achievements are to be reported to the Chief of Naval Personnel via the CO, HSETC (Code 6). 6

SURVEY

What do you think of U.S. NAVY MEDICINE?

We are continually interested in serving the needs of our readers and improving the quality of *U.S. Navy Medicine*. That's why we would very much like to know your thoughts about and wishes for this publication — what you expect and need to know from the monthly official journal of the Navy Medical Department. If you will help us by filling in and returning this questionnaire, you can make *U.S. Navy Medicine* even more responsive to your needs than it is now.

Please complete and return this survey *today*. Instant response ensures the highest quality returns. We appreciate your interest and support.

1. How often do you see *U.S. Navy Medicine*?

- ☐ each issue
- ☐ most issues
- ☐ about half the issues
- ☐ seldom see an issue
- ☐ this is the first issue I have seen

2. You are currently

- ☐ a member of the Regular Navy
- ☐ a member of the Naval Reserve on active duty
- ☐ a member of the Naval Reserve not on active duty
- ☐ other military
- ☐ civilian health care professional
- ☐ other _____

(specify)

3. Your age is

- ☐ under 25
- ☐ 26-35
- ☐ 36-50
- ☐ over 50

4. Your rank is

- ☐ O- _____
- ☐ E- _____
- ☐ GS- _____

5. If a member of the Navy Medical Department, you are in the

- ☐ Medical Corps
- ☐ Dental Corps
- ☐ Medical Service Corps
- ☐ Nurse Corps
- ☐ Hospital Corps

6. How many of the articles in each issue of *U.S. Navy Medicine* do you read on the average?

- ☐ all
- ☐ half
- ☐ a third
- ☐ a quarter
- ☐ one here and there
- ☐ none

7. How many other people read your copy of *U.S. Navy Medicine*?

- ☐ 1-3
- ☐ 4-6
- ☐ 7-10
- ☐ over 10

8. To what extent are *U.S. Navy Medicine* articles:

	HIGH	AVERAGE	LOW
Interesting			
Understandable			
Informative			
Useful			

9. How attractive is the format (layout, typography, headlines, photographs, artwork)?

- ☐ very attractive
- ☐ somewhat attractive
- ☐ no strong feelings
- ☐ somewhat unattractive
- ☐ unattractive

10. In your opinion, *U.S. Navy Medicine* is

- ☐ well balanced in coverage of all Medical Department corps.
- ☐ not sufficiently balanced in coverage of all Medical Department corps.

Explain _____

11. Does this magazine help you understand Medical Department policy?
☐ greatly
☐ somewhat
☐ not at all
12. Does this magazine keep you informed of Medical Department activities?
☐ greatly
☐ somewhat
☐ not at all
13. Does this magazine help you discuss Medical Department activities with people outside your field?
☐ greatly
☐ somewhat
☐ not at all
14. The amount of "in-house" information about Medical Department activities is:
☐ too much
☐ about right
☐ too little
15. The amount of professional material (professional papers, etc.) is:
☐ too much
☐ about right
☐ too little
16. In your opinion, the professional papers in *U.S. Navy Medicine* are:
☐ high-quality additions to the literature
☐ average
☐ of limited value
☐ of no value
17. How many of the standing features — From the Chief, BUMED SITREP, Scholar's Scuttlebutt, Notes & Announcements, Instructions & Directives, Board Certifications — do you read on an average?
☐ all
☐ half
☐ a third
☐ a quarter
☐ one here and there
☐ none
18. What subjects interest you most (number in order of preference)?
☐ Medical Department policy changes
☐ new programs for career progression
☐ new programs of health care delivery
☐ personnel changes
☐ Medical Department history
☐ facility construction
☐ Medical Department meetings and seminars
☐ Other _____

19. Other comments about *U.S. Navy Medicine*:

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Editor
 U.S. Navy Medicine
 Bureau of Medicine and Surgery (Code 0010)
 Washington, D.C. 20372

UNITED STATES NAVY MEDICINE

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NOTICES should be received not later than the third day of the month preceding the desired month of publication.

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THIRD CLASS MAIL



THE PRESIDENT DIGS IN—President Ford (center) digs deep at groundbreaking ceremonies for the Uniformed Services University of the Health Sciences. Other groundbreakers at the 10 July ceremonies were (left to right) RADM A.R. Marschall, commander of the Naval Facilities Engineering Command; Anthony R. Curreri, M.D., USUHS president; David Packard (next to President Ford), chairman of the USUHS Board of Regents; Congressman F. Edward Hebert; and Secretary of Defense James R. Schlesinger.—PAO, USUHS.

U.S. NAVY MEDICINE